REALISING THE REFORM DIVIDEND

A TOOLKIT TO TRANSFORM THE NHS

Dr Annie Williamson,
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SUMMARY

Building an NHS fit for the future is a life-or-death challenge. First-rate health services, accessible when needed, are an imperative for the health of the country. In 2025, we are far from this ideal and things cannot continue as they are.

This persistent state of crisis is a major barrier to reform – it is also the biggest reason that promised reforms *must* succeed. The health of the nation, the health of our economy, and the public's belief in the NHS itself are all on the line. After 15 years of declining services, spiralling costs, and faltering attempts at reform, there is now a window for the sector-wide collaboration and investment needed to improve. If reform fails this time, the NHS may not have another chance.

A truly productive, prevention-first NHS offers the best possible route to fiscal sustainability. New modelling for this report finds that the government's productivity and prevention promises could maintain DHSC expenditure in England around 8 per cent of GDP – compared to the current trajectory towards almost 10 per cent by 2034/35. This equates to a difference of £21 billion per year in spending on health by the end of this parliament.

The 10 Year Health Plan must be ruthlessly focussed on the 'how' of reform. Previous governments have been tempted by setting out broad visions for reform then turning to a plethora of enticingly simple solutions to achieve them: announcing a narrow set of targets, then layering on more and more priorities; seeking to compel competitive performance, then calling for integration and collaboration across teams; promising devolved power and autonomy, before new regulators grip the reins tight if something goes wrong.

This report equips leaders for a different, more effective approach by looking at the evidence on what works in driving reform. Delving into the strongest possible evidence, it unlocks three sets of insights.

1. **A bold plan for change needs a coordinated approach to reform:** in a system as complex as the NHS, no reform lever is a silver bullet. Clarity on the goals of reform, and the best way to coordinate multiple levers to achieve them, must be at the heart of the 10 Year Health Plan.
2. **Established levers for reform can shore up performance but won't drive long-term transformation:** levers like targets, competition and choice, and regulation can bring value to a reform plan, but they must be designed wisely to avoid unintended consequences and work with other improvement levers.
    - **Targets:** the government should avoid setting overbearing central targets; instead it should co-produce a small number of evidence-based targets with local leaders that focus on outcomes rather than outputs and reflect the genuine priorities of NHS systems.
    - **Regulation:** regulation must move away from an inspection-led approach to a continuous improvement model based on the systematic collection and monitoring of real-time data, developing opportunities for peer benchmarking, and systematising quality improvement as the core goal of regulation.
    - **Choice and competition:** patient choice is an important right and a force for better care, yet government should tread carefully when it comes to competition and choice as a lever for improvement. This may offer value in a limited set of circumstances – high-volume, low-complexity acute

settings and urban areas where patients have a variety of local providers to choose between. Yet it also carries major risk of undermining long-term ambitions to transform care, with negative effects on the NHS's core customers – those living with long-term conditions. Future care models should prioritise choice while learning lessons from previous attempted competition reforms.

3. **New levers are waiting in the NHS toolkit:** government should look to new levers to transform the NHS. Our evidence review shows that empowering frontline staff and patients to drive improvement, and deepening the NHS's approach to devolution, both hold particular promise.
    - **Unlocking insights from the frontline:** those providing NHS care are a source of enormous untapped potential when it comes to improving performance and ultimately transforming models of care. NHS trusts and systems must find new ways to involve frontline staff in transformation programmes and make their insights central to ongoing learning and improvement.
    - **Empowering patients:** strengthening the voice of patients at every level and developing a comprehensive care offer for those who use NHS services the most will help reduce cost and improve quality. Government should take steps to drive a 'feedback revolution' in the NHS and support patients with long-term conditions to plan and manage their care more effectively.
    - **Devolving power and resource:** the abolition of NHS England should be the opening shot in developing a new operating model for the NHS. Making systems the core drivers of improvement in the NHS will make the healthcare system more responsive to the communities it serves, but it will require redistributing management and leadership capacity and granting more freedoms to plan services and allocate resources.

NHS reform will require not just vision but effective execution to succeed. The government can only deliver this by understanding which reform levers work best – and in what combination – to deliver true transformation of the health service.

1. THE CHALLENGE AHEAD

Britain's health challenges have reached historic proportions. Life expectancy and healthy life expectancy have plateaued, and in some areas even fallen (Raleigh 2024). More and more of us are living with long-term health conditions, the percentage living with obesity continues to rise, and our collective mental health is in crisis.

The poor underlying health of our population has increased pressure on health and care services and is holding back economic activity and growth (ONS 2025).

The IPPR's Commission on Health and Prosperity argued that arresting the worrying decline in Britain's health would require a whole-society approach, including changes to the places we grow up, live and work in. Despite the need to think beyond the NHS when it comes to building a truly healthy Britain, a high-functioning, accessible healthcare system fit for the needs of a changing population is a crucial enabler in this mission. Unfortunately, our most cherished institution, the National Health Service, remains in a critical condition.

The current government faced an especially tough healthcare inheritance on taking office, with at least three major challenges:

- **deteriorating healthcare access and health outcomes**
- **an NHS workforce pushed to the brink**
- **historic underinvestment holding back productivity.**

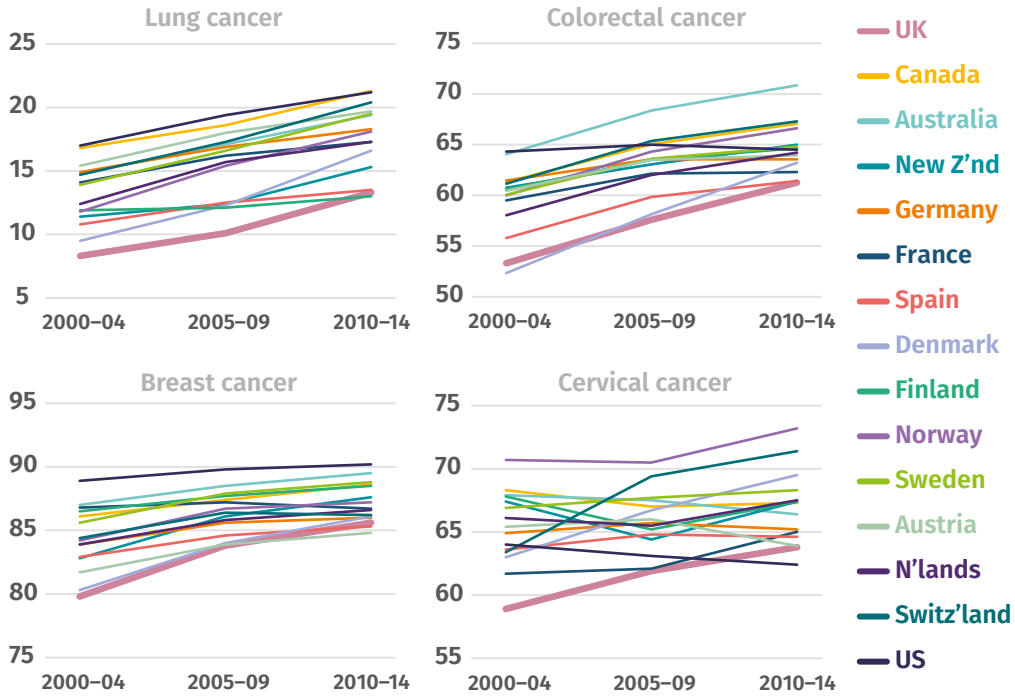
1.1 DETERIORATING HEALTHCARE ACCESS AND HEALTH OUTCOMES

Comparing autumn 2024 to 2009/10, when Labour was last in power, the number of people waiting for diagnostic scans has tripled, and the number waiting more than 18 weeks for elective care has increased twelvefold. Twenty-five times more people waited more than four hours in A&E, affecting 1.6 million people across the autumn quarter last year (Adebowale and Williamson 2024).

Access is not the only issue. Quality of healthcare provision has fallen starkly over the past decade, with avoidable mortality above comparable European nations (Patel et al 2023). Previous IPPR analysis, in conjunction with Carnall Farrar, showed that 240,000 fewer people would have died in the decade from 2010 if the UK had an avoidable mortality rate equal to comparable European countries (ibid). This analysis also highlighted cancer care, a priority area in the government's Plan for Change – where the UK is lagging almost all OECD countries for survival rates (Prime Minister's Office 2024) (see figure 1.1).

FIGURE 1.1: THE UK LAGS SIMILAR COUNTRIES ON SURVIVAL RATES FOR CANCER

Cross country cancer survival: lung, breast, colorectal and cervical cancer



Source: OECD, Carnall Farrar analysis in Patel et al, 'For public health and public finances: Reforming health and social care', IPPR (Patel et al 2023)

1.2 THE NHS WORKFORCE HAS BEEN PUSHED TO THE BRINK

NHS staff have gone to extraordinary lengths to keep patients safe through an unprecedented pandemic, and a decade of austerity before that. This casts a long shadow. High numbers of staff have left the NHS permanently, and those who have remained in the system are physically and emotionally exhausted. In the latest NHS survey, almost a third of staff reported that they still felt 'burnt out' because of work (NHS Staff Survey 2025). Burnout and turnover have in turn led to a loss of senior expertise and declining discretionary effort – staff are far less likely to go 'above and beyond' where they feel overworked and undervalued (Freedman and Wolf 2023; Thompson and Jenkins 2024). A *New England Journal of Medicine* review of the UK, France and US found that "clinicians are increasingly exposed to avoidable moral conflicts engendered by organisational decisions … that compromise care in various ways" (Dean et al 2024).

Despite increased staff numbers overall, debilitating staff shortages continue to hold back key areas including general practice, district nursing and diagnostic radiology which form the bedrock of prevention and community-based care (NHS Providers 2023).

1.3 HISTORICAL UNDERINVESTMENT HAS HELD BACK NHS PRODUCTIVITY

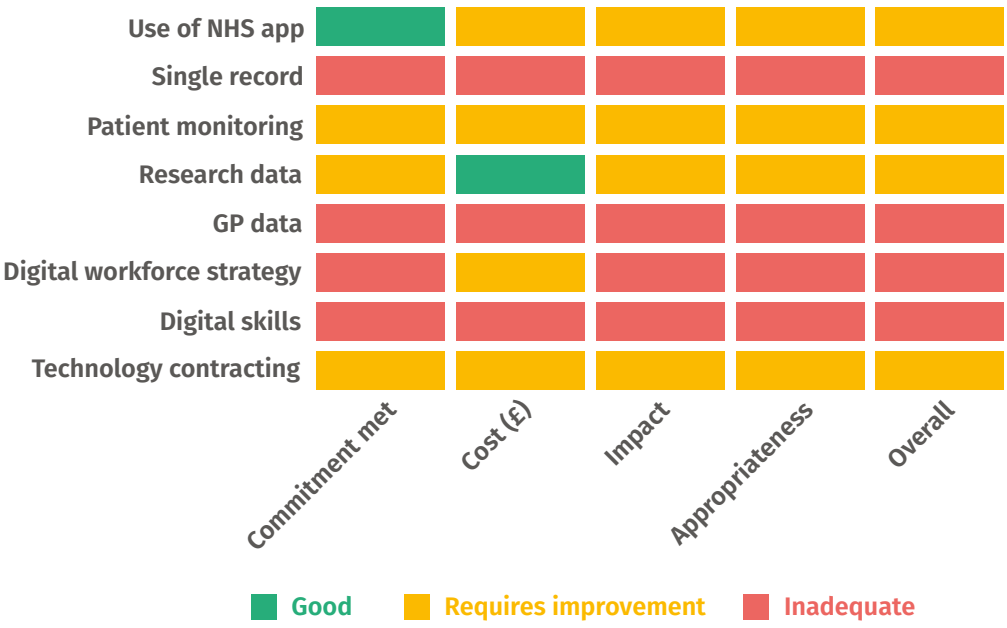
Concerns over NHS productivity have been widespread in recent years. The NHS budget has increased by more than 20 per cent in real terms since 2019/20 and the number of full-time equivalent doctors and nurses has grown by over 25 per cent (Stiebahl et al 2025). However, services have struggled to turn increasing inputs into more activity. There has been some recent progress – with latest data showing that acute sector productivity grew by 2.4 per cent in the first seven months of 2024/25

compared to the same period in 2023/24 (Kelly 2025). Yet overall acute productivity is still estimated to be around 8 per cent below the level it was in 2019/20 (ibid). Returning productivity to its pre-pandemic level and ultimately sustaining rates of productivity growth over the next half-decade will require significant effort and effective reform.

The challenge of boosting NHS activity is the product of long-term underinvestment in productivity building blocks. Clinicians and experts have consistently highlighted that technology and infrastructure are far from optimal. "The NHS is still in the foothills of digital transformation" (Darzi 2024), with fewer CTs and MRIs than almost any comparable country (Patel et al 2023). Consistent underinvestment in capital and infrastructure has held back more productive delivery of care, with recurrent failures to deliver on commitments (figure 1.2; Coyle 2023).

FIGURE 1.2: GOVERNMENTS HAVE HISTORICALLY FAILED TO DELIVER ON NHS INFRASTRUCTURE PROMISES

Health and Social Care Select Committee evaluation of NHS digitisation commitments



Source: Health and Social Care Committee 'Evaluation of Government commitments made on the digitisation of the NHS' (Health and Social Care Committee 2023)

The NHS maintenance backlog – the estimated cost of bringing NHS estates to a minimum expected standard – more than doubled in real terms between 2015/16 (£6.4 billion) and 2023/24 (£13.8 billion) (Fozzard et al 2024). NHS England figures suggest that over the two years to May 2024, there have been 12,000 reported estate failures that have stopped clinical services (Kelly 2024).

Alongside a failure to invest in its estate, equipment and digital infrastructure, NHS organisations have not always been designed strategically to boost productivity in the best possible way. Top-down imperatives to 'do more with less' have been commonplace in the past. Yet those with the most direct insight into the NHS's productivity challenge – frontline staff delivering care – report lower autonomy than prior to the pandemic with just 50 per cent feeling involved in deciding on changes at work (NHS Staff Survey 2025). This means potential contributions

to boosting quality and making care processes more efficient are overlooked. Meanwhile, local leaders also lack decision-making power, with one Trust lead describing a sense of "sitting and waiting" for priorities to be confirmed and funded by distant central teams (Adebowale and Williamson 2024).

1.4 THE NHS FACES A DIFFICULT LONG-TERM PROGNOSIS

Alongside overcoming its difficult inheritance, this government must also grapple with more fundamental challenges.

Major changes in demand for healthcare brought about by a population which is getting older – where more people are living with multiple long-term conditions, and where expectations on what healthcare can achieve are high – have not been accompanied by shifts to the underlying delivery model. Despite waves of reform and major clinical advances in recent decades, our healthcare system remains hospital centric, focussed on the provision of reactive care rather than preventing illness, and far less digitally equipped than other industries.

The government therefore faces a dual task: rebuilding and restoring confidence in existing services, while equipping the system to deal with the challenges of the future. How effectively it navigates this tension between fixing immediate operational problems and developing a new model of care – "flying the plane and rebuilding it at the same time" as former health secretary Alan Milburn put it – will define this government's record on health reform (Smyth 2024).

2. PLANNING FOR CHANGE

To meet the difficult dual challenge of rebuilding and transforming the NHS, the government has announced a series of steps to both boost the Service's current performance and transform it in the long run. On the former, the government has set out clear milestones to get on top of waiting lists and boost productivity and there has been an injection of short-term resource to stabilise performance. On the latter, the government has committed to long-term improvement using a mission approach and set out, within in its 10 Year Plan process, the kinds of transformational shifts necessary to meet long-term challenges.

2.1 SETTING IMMEDIATE PRIORITIES

To deliver on its mission to "build an NHS fit for the future", the government set out its flagship commitment for this parliament as meeting the NHS standard that 92 per cent of patients should wait no longer than 18 weeks for elective treatment (Prime Minister's Office 2024). A plan to meet this commitment, focussed on expanding patient choice, reforming the delivery of elective care, and improving performance oversight was published in January 2025 (NHS England 2025).

To help meet this target, the government committed additional resources to the NHS in its autumn budget. The NHS's day-to-day budget is set to increase by £21 billion and will reach £192 billion by 2025/26. An additional £3.1 billion per year of capital expenditure across health and care is also promised, including investment in technology, surgical hubs and scanners (NHS Confederation 2024).

Alongside additional investment, a productivity target of 2 per cent improvement per year has also been set (Kelly 2024). This is an ambitious goal, given that quality-adjusted productivity grew by 1 per cent on average from 1997 to 2019 – and exceeded 2 per cent in just four years of the entire New Labour period (ONS 2024).

2.2 PLANNING FOR TRANSFORMATION: DIAGNOSING THE PROBLEM

On coming to office, the health secretary commissioned Lord Darzi to carry out a rapid independent investigation of NHS performance. This investigation was intended to serve as a root cause analysis of problems and serve as a starting point for reform.

Published in November 2024, the investigation laid bare the NHS's "critical condition" and highlighted four key drivers of poor performance: austerity and long-term underinvestment in capital; the ongoing effects of the Covid-19 pandemic; a lack of patient and staff voice to drive change across the system; and poor approaches to system management (Darzi 2024).

2.3 PLANNING FOR TRANSFORMATION: ESTABLISHING A HEALTH MISSION

Following Lord Darzi's review, the government formalised its "health mission": to "build an NHS fit for the future". The government's mission builds on the objectives set out in Labour's general election manifesto and sets out three key commitments (Labour Party 2023, Prime Minister's Office 2025).

1. **An NHS there when people need it:** improving ambulance response times, boosting access to general practice, ending long waits in A&E and reducing hospital waiting times for specialist care.
2. **Fewer lives lost to the biggest killers:** improving cancer survival rates, reducing deaths from heart disease by a quarter within 10 years, and reversing the rising trend in the rate of lives lost to suicide within five years.
3. **A fairer Britain where everyone lives well for longer:** with a target to improve healthy life expectancy for all and halve the gap in healthy life expectancy between regions.

This mission-led approach provides a clear, strategic focus for long-term reform, and much-needed accountability for the government to deliver on *health* not just healthcare reform.

2.4 PLANNING FOR TRANSFORMATION: IDENTIFYING STRATEGIC SHIFTS THAT CAN DELIVER REFORM

To meet its longer-term commitment to boost population health and transform the NHS, the government will set out a 10 Year Health Plan focussed on three strategic shifts.

1. **From hospital-led care to care at home or in the community**
2. **From analogue to digital**
3. **From sickness to prevention (DHSC 2024).**

The plan is being developed through Change NHS, a large-scale consultation with those using and providing NHS services. Described by the government as the "biggest ever conversation" about the future of the NHS, this process draws together the public, patient groups, the workforce, policy experts and system leaders, with more than 1 million website visits and tens of thousands of people contributing ideas online or in-person (DHSC 2024a). A plan is expected to be published in spring 2025.

2.5 THE REFORM DIVIDEND: A STRONGER, MORE SUSTAINABLE NHS

The short- and long-term milestones set out by the government target the right set of challenges. Moving to a community-based, digitally led, prevention-first model of healthcare can boost care quality and deliver a better service for patients.

Importantly, it can also help government deal with a long-term fiscal risk – rising health expenditure. Rising health spending is the most important driver of the projected increase in government debt over the next 50 years (OBR 2024), and despite historically low rates of expenditure growth over the past 14 years (Anandaciva 2024), health spending makes up more than 40 per cent of day-to-day departmental expenditure (Stoye et al 2024).

Health demand will grow over time due to demographic trends, while treatment innovation and the nature of healthcare as a labour-intensive, tightly regulated industry mean that NHS spending will need to increase in the coming years. Yet transformation can help moderate this growth, conserving resources for where they are most needed inside and outside the NHS. Improving productivity and boosting population health can therefore pay dividends for the sustainability of the NHS and public expenditure overall.

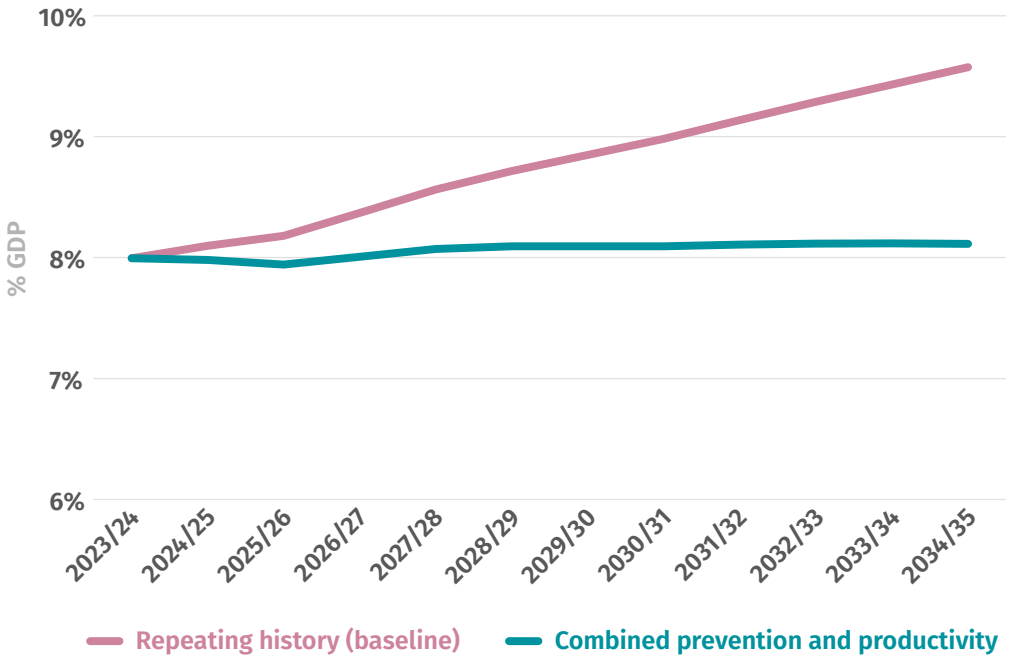
In analysis undertaken with LCP Health Analytics, we have projected healthcare spending in England over the next decade (McDonald et al 2025).[1] This updates

1 See https://www.lcp.com/en/insights/blogs/latest-projections-show-how-productivity-and-prevention-reform-can-bend-the-curve-of-nhs-finances

previous analysis for the IPPR Commission on Health and Prosperity (Patel et al 2023). We analyse the extent to which delivering the government's health agenda can bend the spending curve through promised improvements in health status and productivity. Two scenarios are compared, with model details in the annex.

- **History repeated:** life expectancy follows ONS projections, with flat healthy life expectancy and NHS productivity growth of 0.5 per cent per annum in line with historical trends.
- **Prevention and productivity as promised:** productivity grows at 2 per cent per year, and the health mission to halve the gap in healthy life expectancy between regions is delivered by 2033/34.

FIGURE 2.1: PROJECTED HEALTHCARE SPENDING (DHSC) IN ENGLAND AS A SHARE OF GDP



Source: LCP analysis

If the recent trajectory of stagnant healthy life expectancy and modest improvements in NHS productivity continue, government healthcare spending will need to rise to almost 10 per cent of GDP in the next decade – just to maintain the current level of services.

Conversely, delivering on prevention and productivity promises offers a clear way to bend the curve of healthcare spending. Successful reform to deliver both promises could maintain annual DHSC expenditure at 8.1 per cent of GDP. This would mean saving **£21 billion per year on health by the end of this parliament**, and £53 billion per year by 2034/35, compared to the high-cost path of failing to reform.[2]

This shows the 'size of the prize' of successful reform efforts geared towards boosting prevention and productivity. What is needed is an effective, evidence-based way to deliver.

2 While methodologies differ (primarily because we analyse overall DHSC spending rather than NHS England spending), the proportional impact estimated is broadly in line with the Health Foundation submission to the Spending Review (Health Foundation 2025).

3. A PLAN THAT WORKS: THE NEED FOR BETTER REFORM LEVERS ABLE TO DELIVER

The scale of the challenge facing the NHS demands a bold approach. As the government set out in its health mission, "total, fundamental and long-term reform of our NHS is critical to its survival" (Prime Minister's Office 2025). Or, as health secretary Wes Streeting has put it: "The NHS must reform, or it will die."

For decades health secretaries have set out visions to drive productivity improvements, shift healthcare delivery towards prevention, and integrate care around patients. But effective reform has proved elusive. Our health service finds itself in a paradoxical position – despite successive waves of reorganisation, structural change and transformation initiatives, to those working in and using the NHS it continues to feel frustratingly complex and outdated. While how we bank, date and shop has been transformed, our use of the NHS has largely stayed the same (bar some pockets of innovation). Government in other areas has made progress: the creation of GOV.UK; the digitisation of social security; and the past 15 years of schools' reform. But the NHS continues to lag behind. To put it simply: the NHS is 'the last unreformed state bureaucracy'.

The question that confronts this government is how to deliver *genuine* change in a system as complex as the NHS, where powerful and entrenched interests have proved fiercely resistant to reform. For the 10 Year Plan to succeed it must go beyond setting out an aspirational vision and be squarely grounded in how change can be delivered. This demands reform strategies that are both effective and timely – that is, that can turn the shared vision into reality, and deliver quickly so that those using and working in the health service feel a difference by the end of this parliament.

A relentless prioritisation of 'what works' will be necessary – the government cannot afford to expend scarce resources on costly distractions. So too will be a willingness to challenge long-established ways of working and entrenched power structures where they block transformation. In the NHS's 'reform or die' predicament, trying to win over all stakeholders is neither possible, nor desirable. Charting a brave course for the future is the only option for a government set on delivering a modernised health service.

3.1 LOOKING BEHIND TO FORGE AHEAD

To deliver on its vision, the government must critically interrogate past efforts at reform. Previous Conservative administrations also made reforming the health service central to their aims in government – the limited success they achieved, however, offers salutary lessons to the current government. Table 2.1 sets out some of the key attempts to reform NHS services over the past 14 years and the obstacles they faced to delivering change.

TABLE 3.1: 14 YEARS OF OBSTACLES TO PREVIOUS NHS REFORM ATTEMPTS

Reform proposal	Key goals	Outcomes and obstacles to delivery
Health and Care Act 2022	Formalisation of integrated care systems (ICSs) Merger between NHS England and NHS Improvement Care Quality Commission (CQC) duty to assess council delivery of adult social care	ICSs struggling to deliver promised collaboration and prevention given fiscal constraints (Bliss et al 2024) Considerable ongoing challenges in organising decision-making, with "significant duplication" and governance arrangements still under development (Sanderson 2024) Highly centralised NHS structure, risking "too many people holding people to account, rather than doing the job", and a multitude of regulatory organisations which "encourages too many to look upwards rather than to those they are there to serve" (Darzi 2024) "Significant failings" in CQC (Dash 2024)
NHS Long-Term Plan 2019	Reduce avoidable deaths from cancer, heart disease, stroke Improve cancer, maternity care and mental health access New GP contract, incentivising primary care networks and online consultations Expansion of personalised care models and social prescribing	Covid-19 pandemic derailed clinical goals, with major delay and disruption (Thorlby et al 2021) Big implementation gap around staffing (Taylor 2022) "Plethora of other central plans for the NHS" (ibid)
Five Year Forward View 2014	Sets out "seven new models of care" including multispecialty community providers (MCPs) and acute care collaborations, through 50 "vanguard" sites Consolidating stroke and some cancer services around specialist centres	New approaches and models of care proved difficult to embed and scale, with efforts to spread beyond vanguard sites faltering (Ham et al 2016). Local leaders required to draw up "sustainability and transformation plans", but relied on willingness of organisations to collaborate (ibid) Funds intended for transformation were instead used to reduce Trusts' financial deficits and sustain existing services (NAO 2018)
The Health and Social Care Act 2012 (the Lansley reforms)	Increased competition and wider use of market-like mechanisms Establishment of NHS England and clinical commissioning groups Abolition of strategic health authorities and primary care trusts	Jeremy Hunt, health secretary in 2012, described fragmentation caused as "completely ridiculous" (see Timmims 2020) Little change to private provision of care to NHS patients, with over 90 per cent of services still delivered by NHS providers (Ham 2015) Described as 'a vacuum in system leadership at a local as well as a national level' (ibid)

Source: Authors' analysis

This evidence shows that bold commitments and agendas for change have been accompanied by one or two simple delivery 'levers': the introduction of central targets; the introduction of markets and competition; the removal of regional authorities; the reintroduction of regional authorities.

The failure of reform efforts has, in large part, stemmed from policymakers being overly optimistic about the ability of individual levers to catalyse change across a

complex system. No single lever should be heralded as a 'silver bullet', fit to tackle all problems that the NHS faces.

Relatedly, policymakers have often thought about 'levers' in isolation from the institutional context in which they are being 'pulled'. In some instances, new levers have been pulled without considering the way in which they interact with previous waves of reform.

For instance, encouraging providers to collaborate and join care up around the needs of patients by developing new governance vehicles (sustainability and transformation plans, Integrated Care Systems) had limited impact when other institutions were geared towards facilitating competition. Similarly, moves to 'devolve' more power and responsibility to regions and systems were unlikely to drive significant change where regulation is highly centralised, and where providers and systems were still expected to meet a large number of targets set by the centre.

To develop a new roadmap for reform, government should start by asking, "When does each lever succeed or fail, and why?" and "How can levers be deployed effectively in conjunction with one another to bring about successful reform?"

The next chapter explores the strongest available evidence to bring informed and rigorous perspectives to these challenges.

4. WHAT WORKS, WHEN? A TYPOLOGY OF APPROACHES TO HEALTH SERVICE REFORM

The implementation challenge for NHS reform requires not just vision but effective execution. The government can only deliver this by understanding which reform levers work best, and in what combination, to deliver true transformation and build an NHS fit for the future. This chapter brings together the best available evidence on key reform 'levers' – that is, instruments available to governments to achieve system-wide change and progress towards policy goals.

These insights can support a better, evidence-based approach to the 'how' of reform, applicable regardless of the specific details of 'what' the 10 Year Plan consultation concludes.

4.1 IDENTIFYING REFORM LEVERS

We selected six levers which represent a policy *choice*, meaning an approach not necessarily included in every health system at the outset but which have commonly been used to reform health services like the NHS:

1. **targets and performance management**
2. **central regulation and inspection**
3. **devolution and autonomy**
4. **choice and competition**
5. **learning and improvement systems**
6. **patient and community empowerment.**

These six levers were selected based on available evidence, then tested and refined with a range of health leaders and policy experts. This means we did not include 'enablers' such as funding and leadership that are common requirements of all effective health service reform. This chapter will discuss the relationship between the six selected levers and these enablers.

We undertook a literature review of the strongest available evidence, including systematic reviews, NHS and global case studies (see box). This was used to identify how the lever works in theory, what assumptions must be true for the lever to succeed, and key examples.

Every lever has both merit and drawbacks. Through thematic analysis, we identified contexts where each lever is likely to work, those it is less suited to, and wider impacts including benefits or collateral harms. An evidence table for each lever summarises these findings.

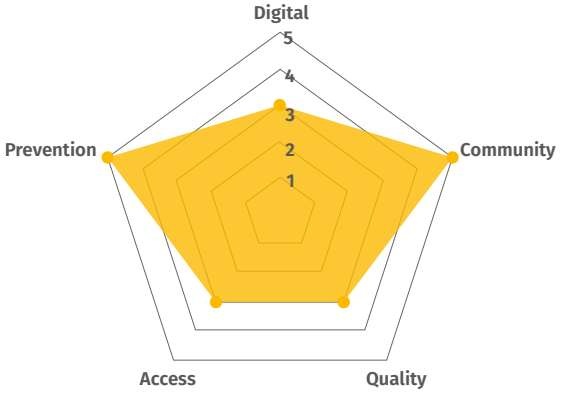
SEARCH METHODOLOGY

- We sought to cast the widest-possible net across published and grey literature. As a result, we undertook an extensive but non-systematic review given the breadth of material.
- Each search began with a review of relevant PubMed-cited trials and meta-analyses from the past 20 years. Articles were assessed based on title, abstract and/or full-text.
- We then proceeded to snowball sampling of citations from key articles and grey literature, and consulted with multiple sector experts to identify key sources we may have missed.
- This search considered all countries comparable to England, including OECD and other comparators. It focussed on, but was not limited to, health system evidence.

4.2 ASSESSING LEVERS

We synthesised our findings into comparative metrics. Two researchers independently rated each lever as **'high'**, **'moderate'** or **'low'** efficacy across five government priorities:

1. **improving access to services** (including waiting lists and equity)
2. **improving quality** (including process and health outcomes)
3. **potential to deliver prevention**
4. **community**
5. **digital shifts.**



These metrics are presented in a visual pentagon indicator, where a fuller pentagon represents a higher rating for that aim. The pentagon colour represents the likely **cost** for the lever to succeed, assessed on a three-point scale:

- **£**: minimal additional government spending required, or lever crowds in other funding
- **££**: additional cost referenced in evidence base, but either limited or upfront only
- **£££**: significant new and sustained investment required.

Finally, we rated the overall **quality** of the evidence available as:

- **+++:** strong evidence including systematic reviews, meta-analyses and RCTs
- **++:** widespread applied evidence or case studies, but not extensive top-tier evidence
- **+:** either lack of evidence or evidence of no significant effect.

These assessments are summarised in table 4.1. Which metrics matter most is a question for policymakers to weigh up – and will likely evolve over the course of a 10-year reform agenda.

TABLE 4.1: SUMMARY OF EFFICACY RATINGS FOR EACH LEVER, ACROSS SEVEN METRICS

Lever	Improve access	Improve quality	Prevention shift	Community shift	Digital shift	Cost to succeed	Robustness of evidence
Targets	High	Low	Low	Low	Mod	£££	+++
Central regulation and inspection	N/a[i]	Mod[ii]	Low	Low	Mod	£££	++
Devolution and autonomy	Mod	Mod	High	High	Mod	££	+/++
Choice and competition	Mod [iii]	Low	Low	Low	Low/ Mod[iv]	££	+++
Learning and improvement	Mod/ High	Mod	Mod	High	High	££	++
Patient empowerment	Mod/ High	Low/ Mod	High	High	Low	£/££[v]	+/++

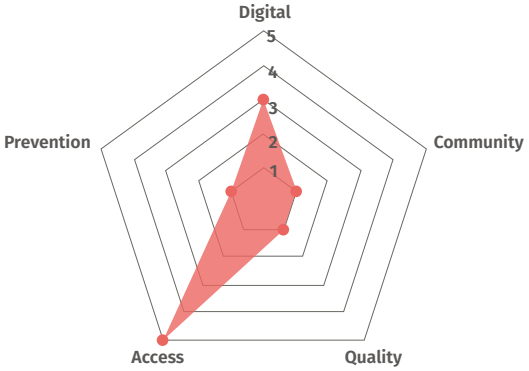
Notes: i Regulation not primarily used to improve access in the evidence reviewed.
ii Good evidence of regulation preventing significant harm, but not driving excellence.
iii Some evidence of shorter inpatient stays, but also widens access inequity.
iv Evidence of increased uptake of technology, but some choices unproven and costly.
v Low upfront cost and crowds in funding, though may require resources to formalise and scale.

LEVER 1: TARGETS AND PERFORMANCE MANAGEMENT

How does this work? Central leaders set a number of key performance targets and hold local leaders to account publicly and/or privately.

What must be true for success? (Bevan and Hood 2006)

1. Target outcome is a good proxy for overall performance.
2. Key targets can be accurately measured and achieved, with 'gaming' behaviour minimised.



Cost: £££ Evidence: +++

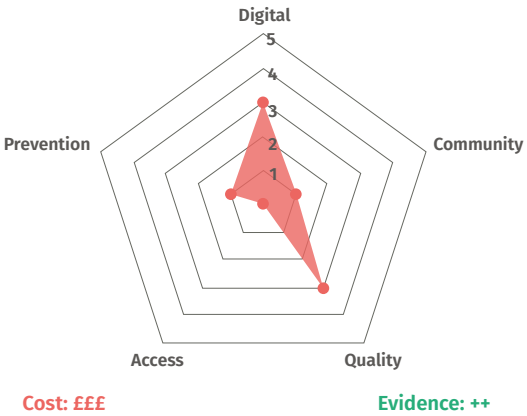
When has this lever been used?

1. NHS Trust 'star' ratings, 2001–05 (Hampton 2005; Bevan and Hood 2006).
2. GP Quality and Outcomes Framework (QOF) (NHS Digital 2024).
3. Dartboard-style interregional performance evaluation in Italy, Australia and regional UK (Vola et al 2022; Goodman et al 2013).

When does the lever work?	Less suited to?	Wider impacts (secondary benefits and collateral harms)
1. Specific, limited & measurable - New Labour elective targets improved access over short term (Propper et al 2008; Kriendler 2010) - NHS star ratings improved measured targets in short term, yet long-term risks (Bevan and Hood 2006; Bevan 2025) - Systematic review: early QOF may have slowed rise in emergency admissions and mental illness; unclear if causal (Forbes et al 2017) **2. Co-produced, well-evidenced targets** - Systematic review: co-production and health focus helps build clinician buy-in (Kondo et al 2016) - Targets must be based on robust evidence to improve outcomes (McColl et al 1998) - Dartboard-style diagrams better for comparative judgements than single aggregate targets, eg Australia, Italy (Nuffield Trust 2013; Goodman et al 2013) **3. Ongoing major funding** - Essential to 2000s waiting lists success (Blythe and Ross 2022) - Systematic review: incentives must be large enough to motivate behaviour, but not so large as to encourage gaming (Kondo et al 2016)	**1. Driving quality, not just output** - Systematic review: ineffective to improve hospital quality or health outcomes (Eckhardt et al 2019) - 'Star ratings' risk scandals and undermine learning (Bevan 2025) - QOF led to excess prescriptions, worse care for non-covered conditions (Dixon et al 2011; MacBride-Stewart et al 2008) **2. Driving prevention** - Evidence review: incentives have "small, if any, effects" in prevention to date (Christianson et al 2008) - Systematic review finds "no clear evidence" QOF improves mortality (Forbes et al 2017) - Literature review: risk excessive concentration on short term (Mannion and Braithwaite 2012) **3. Sustained long-term change** - Systematic review: improve waiting lists only temporarily (Kriendler 2010) - NHS plateau by 2007, leaders noting a "slightly tired, perhaps even complacent" government mindset (Blythe and Ross 2022)	**1. Risk low staff morale** - "Targets and terror" harmed trust and morale (Mannion and Braithwaite 2012) - Organisational culture, morale and recruitment can be negatively affected by a poor rating (Nuffield Trust 2013) - "Blame game" in performance management (James 2004) **2. Measurement fixation and distorting local priorities** - Systematic review: may divert resources from other patients or services (Kriendler 2010) - GP 48-hour target reduced continuity, access improved for chronically ill but not general patients (Campbell et al 2010) - Some A&E triage targets were costly in resources, with little benefit (Smith 1995) **3. Risk of gaming targets** - "Going easy" to avoid more demanding targets (Mannion and Braithwaite 2012) - May deter top performers from delivering quality beyond target (Bevan and Hood 2006)

LEVER 2: CENTRAL REGULATION AND INSPECTION

How does this work? State-run regulator undertakes inspections and assesses providers, professionals or medical services based on pre-agreed standards.



What must be true for success?

1. Inspection criteria are good proxy for overall performance, assessed frequently and consistently (Beaussier et al 2020).
2. Clear models of care, with accountability and designated organisations responsible for meeting standards.
3. Appropriate use of incentives and sanctions (Walshe 2022).

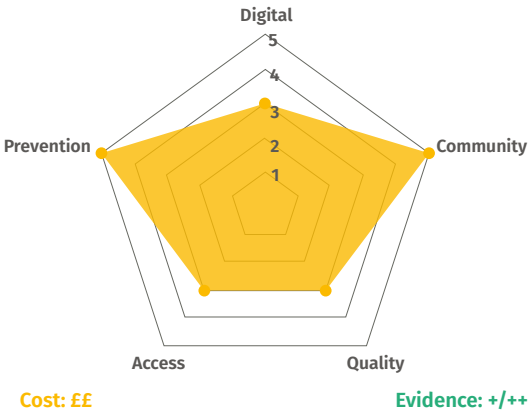
When has this lever been used?

1. Care Quality Commission (CQC).
2. Medicines and Healthcare Products Regulatory Agency, responsible for specific regulation of safety and innovation.

When does the lever work?	Less suited to?	Wider impacts (secondary benefits and collateral harms)
1. Specific high-stakes issue, requiring expert oversight: - UK Medicines and Healthcare Products Regulatory Agency (MHRA) regulates medication and device safety, balances with innovation (Richards and Hudson 2016) - Clinical trial regulation key to transparency and patient protection (Maheriya et al 2024) **2. Clear accountability and monitoring** - Regulation must prioritise highest priority risks to monitor and enforce, requiring clear goals and outcomes (Beaussier et al 2016) - New Labour criticised for inconsistent standards that varied in depth, scope and specificity (Bevan 2011) - Effective regulators work with and through stakeholders including patients, consumers, staff to extend their oversight (Walshe 2002) **3. Specific, well-chosen standards** - Effective regulators deploy varied incentives and sanctions depending on the organisation and objectives in question (Walshe 2022) - Evidence for developing common language and agreed objectives, as achieved in other industries like airline safety (Macrae 2014) - South African RCT: improved compliance with pre-selected hospital standards, but no effect on overall quality (Salmon et al 2003)	**1. Sustain long-term change** - Cochrane: sparse evidence overall on improving health through regulation (Flodgren et al 2016; Sutherland and Leatherman 2006) - UK infection inspections made no difference to MRSA trend (OPM 2009) - Early Ofsted did not improve exam performance for most schools (Shaw et al 2003; Hood et al 1999) **2. Under-resourcing of inspections** - Dash Review of CQC found almost 60 per cent fewer inspections in 2023–24 than 2019–20. Some NHS ratings now 10 years old, and 19 per cent of locations have never been rated (DHSC 2024c) - Literature review: relying on inspection is too costly, too weak and inimical to dynamic change (Ham et al 2016) **3. Primary and community care** - CQC primary care inspections costly, infrequent and poorly correlated with patient satisfaction or chronic disease management (Allen et al 2019) - CQC limited as less improvement capability/support in general practice and social care (Smithson et al 2018) - Risk at time of hospital discharge is not "uniformly recognised [...] nor sufficiently addressed" by regulators (Moore 2020)	**1. Unclear effect on collaboration** - Literature review: "toxic impact of fear" in workplace (Ham et al 2016) - Getting It Right First Time (GIRFT) national team inspect specialty services, eg orthopaedics; national improvement, though cannot be attributed to GIRFT alone (Barratt et al 2022) **2. Regulator and provider costs** - Deterrence carries "very high costs" for sustained inspection and enforcement (Walshe 2002) - Ofsted rating children's social care "inadequate" drives up costs and use of agency staff (Hood and Goldacre 2021) **3. Bureaucracy and frustration** - Overlapping fragmented regulators, diluting impact (Vincent et al 2020) - CQC focus on individual providers; less tenable as provision becomes integrated (Smithson et al 2018) - Staff validation criticised as bureaucratic, inconsistent, and unpopular (Browne et al 2021) - Dash Review of CQC: structural change had reduced expertise, seniority, and positive engagement by regulators (Dash 2024)

LEVER 3: DEVOLUTION AND AUTONOMY

How does this work? devolve responsibility to local leaders, within service or locally elected. Some models grant 'earned autonomy' or jointly set a small number of KPIs, while others transfer full responsibility and accountability to regional health leaders.



What must be true for success?

1. Regional leaders have, or can develop, the resources, capabilities and local expertise to plan and deliver better services.
2. Different local organisations (inside and outside NHS) can collaborate effectively.

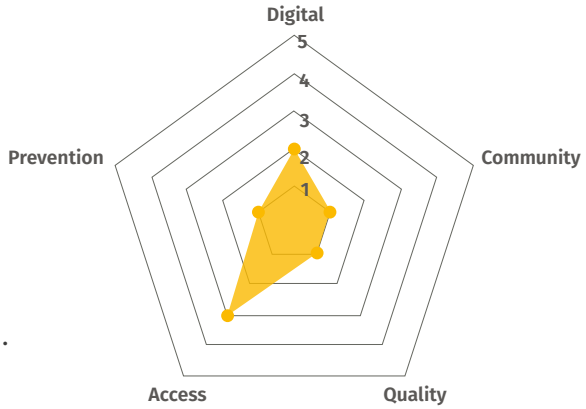
When has this lever been used?

1. Greater Manchester devo-health (Britteon et al 2022)
2. NHS Foundation Trusts (Exworthy et al 2010)
3. Regional health boards, Victoria (Ham and Timmins 2015)

When does the lever work?	Less suited to?	Wider impacts (secondary benefits and collateral harms)
1. LT quality and community goals - UK model: devolution to Greater Manchester saw modest increase in life expectancy vs control (Britteon et al 2022) - OECD-wide comparative models: health decentralisation linked to better prevention, satisfaction, and lower infant mortality (Durmuş 2024; Jiménez-Rubio 2010) **2. Co-produced accountability** - In Foundation Trust model, formal metrics provide safety net though weak incentive for top performers; reputation and local autonomy are key (Exworthy et al 2010) - Australian evaluation: boards co-design local KPIs with health department, earned autonomy if met (Ham and Timmins 2015) - Hewitt review: insufficient autonomy a key factor holding back delivery on long-promised prevention (Hewitt 2023) - NPM most effective when involved local authorities in target setting (James 2004) **3. Infrastructure to collaborate** - Greater Manchester local actors built shared political efforts (Lorne et al 2019) - NHS 25-case evaluation: successful collaboration requires institutions to engender trust (Aunger et al 2022)	**1. Retained central control** - NHS qualitative review: intense focus on national targets could undermine local partnerships (Gowar et al 2024) - Decentralisation focus may mask parallel centralisation (Exworthy et al 2010) - Portugal attempted decentralisation from 1990, but funding and power still centralised; several major state failure risks identified (de Campos 2004) **2. Under-resourced aspirations** - ICS survey suggests acute financial deficits limiting shift from hospital to community (Bliss et al 2024) - New Zealand case studies: plans held back by inability to implement quickly with appropriate and timely funding support (Lovelock et al 2017) **3. Reducing postcode lotteries** - New Zealand devolution initially had 20 small regional boards, with confusion and inequality (Tenbensel et al 2023) - Decentralised autonomy may fragment health systems (Exworthy et al 2010) - However, UK researcher argues *for* devolution as a response to current postcode lottery and differing local needs (Ross and Tomaney 2001)	**1. May increase efficiency** - Literature review: generally improves efficiency and political accountability (Costa-Font 2012) - Spain improved efficiency and reduced expenditure, attributed to better budget allocation (Costa-Font and Moscone 2009) - North West London ICS empowered to collaborate at local leadership level, increased theatre utilisation from 70 per cent to 83 per cent (Bliss et al 2024) **2. Competitive innovation** - Spain: devolution led to efficiency improvements in six of the last 10 Autonomous Regions to receive health powers (Armenteros-Ruiz et al 2024) - In environmental policy, US states act as "laboratories for reform" (Sapat 2004) **3. Decisions closer to community** - Increased local "decision-space" if true devolution (Exworthy et al 2010) - Canterbury, NZ set goal that "people should stay well in their own homes and communities as far as possible"; saw higher community spend, achieved lower acute admissions and stronger primary care (Charles 2017)

LEVER 4: CHOICE AND COMPETITION

How does this work? Local providers compete to attract patients, who bring funding attached. Patients are encouraged to choose between several providers based on published outcomes.



What must be true for success?

1. Patients (across demographics) sufficiently informed and motivated to move to better providers (Kreindler 2010).
2. Key outcomes accurately measured and communicated.
3. Lower-performing providers will respond to patient flows by improving quality (Dietrichson et al 2020).

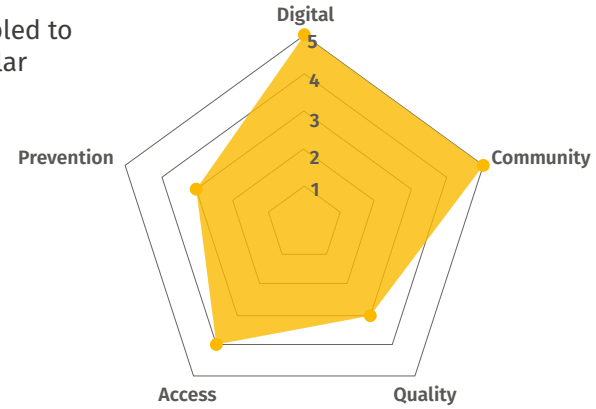
When has this lever been used?

1. New Labour Patient Choice (Robertson and Thorlby 2008).
2. Scandinavian primary care reforms 2000s (Dietrichson 2020; Ge 2024).

When does the lever work?	Less suited to?	Wider impacts (secondary benefits and collateral harms)
1. May improve existing top providers - NHS GPs offering choice saw patients sorting to better hospitals (Gaynor et al 2016) - Areas with lower competition were linked to more heart attack deaths (Gaynor et al 2013) - UK studies: better surgery outcomes in areas with high competition (Aggarwal 2019; Han 2023) **2. Shorter stays for some** - NHS reform: areas of higher competition saw shorter length of stay for elective surgeries though no effect on occupancy (Longo et al 2019; Aggarwal 2019); however, also saw increased cancellations (Bloom et al 2015) **3. Central coordinator to plan care** - Systematic review: New Labour electives plan required a central coordinator to identify long-wait patients and proactively offer switch to an alternative provider (Kreindler 2010; Dawson 2005; Dawson 2007) - Risk of "choice overload" generating health uncertainty, unless general GP coverage to help coordinate care (Jilke et al 2015; Herwartz and Strumann 2024)	**1. Primary care/prevention** - Sweden: no change in access or avoidable admissions (Dietrichson et al 2020); more avoidable admissions for low-income elders, implying worse primary care (Sveréus et al 2024) - Also saw GPs issue more sick leave and prescribe more medication (Dietrichson et al 2020) **2. Leaving choice to patients** - Systematic review: low uptake if patients left to choose between providers alone (Kreindler 2010) - Denmark: 5 per cent used right to choose hospital (Siciliani and Hurst 2005) **3. Mixed evidence on quality** - "Little evidence" greater choice will drive quality (Fotaki et al 2008) - NHS reform "did not act as lever to improve quality'" focussed on waiting lists targets and reputation (Dixon et al 2010) - Unclear if NHS heart attack deaths rose or fell (Propper et al 2008; Cooper et al 2011) - Australia: reform increased hospital mortality (Palangkaraya and Yong 2013)	**1. Private sector outsourcing** - Systematic review: lower quality, higher cost (Kreindler 2010) - Norway: private "cherry-picking" of patients with fewer comorbidities (Ge et al 2024) **2. Risk inefficiency without clear cost savings** - Systematic review: may undermine cooperation (Kreindler 2010) - Risk under-used capacity, and spending on unproven technology (Aggarwal et al 2017) - NHS reforms saw no effect on cost overall (Longo et al 2019) **3. Widen inequalities by education and ability to travel** - Systematic review: better educated people more likely to use choice (Fotaki et al 2008) - Sweden and France saw widened socioeconomic inequity (Milcent 2023; Gustafsson et al 2024) - Australia: rural-urban divides widen (Palangkaraya and Yong 2013)

LEVER 5: LEARNING AND IMPROVEMENT SYSTEMS

How does this work? local leaders and frontline staff enabled to lead ongoing improvement based on experience and regular evaluation. Central leaders may set overall outcomes and support accountability/knowledge-sharing, but less direct oversight.



Cost: ££ Evidence: ++

What must be true for success?

1. Improvement models unlock local understanding of inefficiencies, priorities, patient needs and potential solutions (Hardie et al 2022).
2. With the right structures and leadership, a range of perspectives can be integrated into coherent decision-making (Taylor et al 2015).

When has this lever been used?

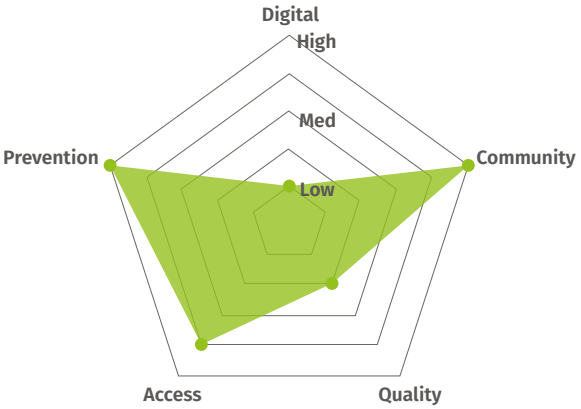
1. East London Foundation Trust quality improvement (IHI 2024).
2. NHS-Virginia Mason Institute (NHS-VMI) lean improvement pilot programme across six NHS trusts (Burgess et al 2022).

When does the lever work?	Less suited to?	Wider impacts (secondary benefits and collateral harms)
1. Improving multi-team care processes - Systematic review: team-led improvement shortens length of stay in emergency and outpatient departments (Tlapa et al 2020) - NHS trial improved surgical safety through "lean" methods (McCulloch et al 2016) - ELFT streamlined local pathways across several providers (Shah and Course 2018) - Learning systems engage communities, with range of perspectives (Hardie et al 2022) **2. Quality leadership and staff engagement** - Systematic review: high-performing hospitals feature effective leaders and interdisciplinary teamwork (Taylor et al 2015) - Effective learning needs leaders, board focus and communication (Jones et al 2017) - NHS-VMI: overall benefit offset in two trusts by leadership challenges (Burgess et al 2022) - Clinician-led governance helps overcome professional siloes and drive innovation (Bolous et al 2023) **3. Digital/data-led implementation** - Systematic review: most "lean" digital interventions significantly improved patient flow and turnover time (Tlapa et al 2022) - NHS case studies of learning-led digital rota tools, boosting staff retention (Hainey 2021; Galloway et al 2022)	**1. Long-term outcomes uncertain** - Systematic review: "lean" (not including other methods) doesn't see long-term mortality impact (Moraros et al 2016) - However, further systematic review: team-led improvement the only strategy to improve safety (Morello et al 2013) - Improvement methods in geriatric care reduced risk of mortality by 20 per cent (Silvester et al 2014) **2. Lack of time and/or resources** - Major NHS barrier (Slater et al 2012; Robertson et al 2013), including priority areas – primary care (Gosling et al 2019) - Risk sidelining if other priorities divert focus and resource (Hunter et al 2014) - Lack of incentives to improve in NHS relative to elsewhere (de Silva 2015) **3. Scaling and sustaining change** - Most NHS improvement is small-scale (de Silva 2015), though some examples scaled effectively (Albury et al 2018) - Hard to evidence impact, with few large evaluations and limited performance measures (Burgess et al 2022) - Systematic review: of six NHS studies of lean reporting on sustainability, two reported success (Woodnutt 2018)	**1. Improve efficiency and access** - Systematic review: decrease outpatient waiting times, with shorter waits for appointments and admitted length of stay (Tlapa et al 2020) -Systematic review: efficiently compare treatments by embedding trials into clinical care (Casey et al 2021) - NHS-VMI: 62 per cent improvement in process time (Burgess et al 2022) **2. Cost savings over time** - Systematic review: reduces waste and improves value (Evans et al 2023) - Learning requires digital infrastructure, but then adds value (Hardie et al 2022) - "Lean" methods reduce low-value care, improve financial outcomes (Narayanan et al 2022; Shortell et al 2021) **3. Staff morale?** - Literature review: boosts morale, but intensifies work (Mahmoud et al 2021) - NHS-VMI: all trusts improved staff retention, though national trends also improving (Burgess et al 2022) - Systematic review: "authentic leadership" focussed on supportive work environments improves job satisfaction and performance (Alilyyani et al 2018)

LEVER 6: PATIENT AND COMMUNITY EMPOWERMENT

How does this work? We focus on patient and community empowerment to improve service design and delivery at the system level. This includes patient and group advocacy, involvement in service design and co-production, and empowerment to deliver services, such as peer support.

This doesn't encompass empowerment to improve one's own care, such as through shared decision-making – an important approach analysed in detail elsewhere (Redding et al 2016).



Cost: £/££ **Evidence: +/++**

What must be true for success?

1. Patients and communities have capability and power to identify local needs and develop solutions.
2. Empowerment can be facilitated without undermining local ownership and agency.

When has this lever been used?

1. HIV community mobilisation globally (Caswell et al 2021).
2. UK Common Ambition programme funds 'collaborative communities' for chronic disease, learning disabilities, homelessness and HIV testing (Brown 2024).

When does the lever work?	Less suited to?	Wider impacts (secondary benefits and collateral harms)
1. Active patient community - HIV community transformed equity and access (Caswell et al 2021) - Common Ambition partnerships built new care collaborations (Brown 2024) - Effective NHS collaboration examples, eg British Muslim Heritage Centre and diabetes care (NHS England 2022) **2. Community-based prevention** - NIHR systematic review finds improved behaviours, outcomes, social support (O'Mara-Eves et al 2013) - NHS community health worker pilot improves vaccination, cancer screening and reduced GP visits 7 per cent (Junghans et al 2024; Owolabi 2024) **3. Accessing hard-to-reach groups** - Systematic review: more appropriate, accessible and effective care (O'Mara-Eves et al 2013) - US RCT: paired barbershops with pharmacists, improved blood pressure control (Victor et al 2018)	**1. Scale innovative models?** - Literature reviews: hard to scale and retain ownership (Rifkin 2014; Hampton et al 2025) - Variation in quality of public engagement (McKevitt et al 2018) **2. Difficult to formalise** - Systematic review: patient/public involvement not well defined, hard to evaluate (Mockford et al 2012) - Peer support sits at boundary of formal and informal; role for more charities, community (Q Lab 2024) - US RCT of coaching HIV patients increased "patient activation" but didn't change health outcomes (Carroll et al 2019) **3. Over-centralised system** - NHS studies highlight over-bureaucracy and "late" PPI after decisions made (Hatfield et al 2023; Meyrick and Gray 2018)	**1. Overcome fear/mistrust** - Systematic review: community engagement improves vaccine uptake (Xie 2024) - Reduced LGBTQ+ stigma, boost health seeking (Biesty et al 2024) **2. Potential cost savings** - Reduces hospitalisations, GP and emergency department visits (Bu and Fancourt 2021; Anderson et al 2022) - Systematic review: some interventions reduce cost, but mixed (Jack et al 2016) **3. Risk variation between areas and conditions** - Patient/public involvement varies across providers (Smiddy et al 2015) - Ethnic disparities in level of patient activation, though health education mitigates (Eneanya et al 2016).

5. BUILDING THE REFORM TOOLKIT THE NHS NEEDS

The NHS faces a twin challenge over the course of this parliament: improving performance to meet the standards that patients and the public expect while transforming its delivery model to meet the demands of the future. It requires a policy toolkit to address both imperatives, and to sequence and prioritise reform to do so in the most cost-effective and high-impact way.

This report has set out the evidence base on key reform levers available to improve healthcare systems. This final chapter draws together three core lessons for policymakers going forward.

LESSON 1: BE CLEAR ON THE GOALS YOU ARE TRYING TO ACHIEVE AND COORDINATE REFORM LEVERS TO DRIVE CHANGE

The starting point for any successful change programme is clarity about what reform is trying to achieve. Developing a clear set of goals and stress-testing the potential tensions must occur before considering the levers that are best placed to achieve them. The government's current approach to reform has had a welcome focus on goal setting with the three 'shifts' offering a clear direction of travel for reform. However, the short-term goal to restore performance in hospitals, sits uneasily with a longer-term vision to move care out of hospital and shift the delivery model from treating to preventing illness. Potential tensions between these goals should be set out clearly to ensure that reform efforts can help secure improvement while not undermining broader, more transformative ambitions.

After goals have been set, levers to enable change must be thought about strategically. The NHS is a complex, interdependent system and no policy lever can drive change on its own. Change happens when multiple levers work together in a coordinated way.

The empirical analysis undertaken reveals that certain levers share key characteristics. For instance, targets and patient choice tend to be most successful in delivering specific, measurable and precise goals. Learning and devolution approaches require a greater degree of trust and enabling leadership – then this can unlock the best of frontline teams.

Identifying approaches that complement each other is pivotal to an effective toolkit that coherently addresses a range of reform priorities. The National Health Inequalities Strategy sets a compelling example of how to pursue bold aims through a holistic reform plan (see case study).

Crucially, understanding where levers contradict one another is equally essential to avoiding past reform mistakes. A proliferation of centrally set targets and heavy-handed performance management, while potentially able to turn around poor performers, may undermine long-term goals to develop a local-led shift to community and encourage learning and improvement.

CASE STUDY: NATIONAL HEALTH INEQUALITIES STRATEGY 1997–2010

The UK government led a systematic attempt to reduce health inequalities in England, aiming to reduce by at least 10 per cent the gap in life expectancy between the fifth of local authorities with the worst health and deprivation, and the population as a whole (Barr et al 2017). The strategy successfully reduced inequality. A clear decline was seen in the life expectancy gap, as well as specific condition and risk factor prevalence, while life expectancy inequalities increased before and afterwards (ibid; Vodden et al 2023).

This was a cross-departmental strategy with four key themes: supporting families; engaging communities in tackling deprivation; improving prevention, treatment and care; and tackling the underlying social determinants of health. Levers and enablers included:

- a single, clear, outcome-based **target**, with further local targets for inequalities
- regional **devolution and autonomy** for area-based regeneration and health initiatives
- national **regulation** to protect the most vulnerable, including introduction of the national minimum wage and tax and benefit changes to reduce child poverty
- supported **learning systems**, with a Health Inequalities National Support Team providing technical advice for areas to implement evidence-based approaches
- strong **resourcing**, with an estimated £20 billion spent from 1997 to 2007.

LESSON 2: TARGETS, CHOICE AND REGULATION CAN SHORE UP PERFORMANCE, BUT WON'T DRIVE TRANSFORMATION

Our analysis suggests that the levers relied on most heavily in healthcare reform over the past two decades – target setting, choice and competition, and regulation – can play a role in recovering performance but won't drive fundamental transformation in the NHS.

Though they may help shore up performance in the short term, policymakers should be aware of the negative unintended consequences that these levers can bring. Most importantly, they should think carefully about the ways in which these approaches can 'lock' our healthcare system into current ways of working and militate against the more transformational change that the government aspires to.

Targets should be used sparingly and judiciously

Policymakers should be judicious over when and how they impose performance targets. Rigid target setting can come at a significant cost. Setting and enforcing additional targets imposes large administrative costs, can have negative effects on an already demoralised workforce, and can distort long-term priorities as providers 'hit the target but miss the point'.

Fortunately, the current government has begun to reduce its reliance on central target setting. The most recent NHS operational planning guidance reduced the number of national targets set on systems and providers from 32 to 18 (O'Dowd 2025), while the newly renegotiated GP contract has retired 32 pay-for-performance, Quality and Outcome Framework indicators. These are welcome first steps, but the government should go further in reducing dependence on targets.

Nonetheless, there is a place for accountability measures, and targets can be part of this if used well. When setting targets policymakers should do the following.

- **Set a small number of evidence-based, co-produced targets that reflect genuine system priorities: targets are most effective when those delivering against them believe they reflect genuine system priorities and are tools for benchmarking and improvement, not just top-down performance management. Several evidence-based approaches exist to deliver these goals and combine the best of targets with learning and improvement, including compelling 'dartboard'-style diagrams that show better performance through indicators closer to the green centre (Bevan et al 2018).**
- **Focus on outcomes rather than outputs: targets have been the favoured lever of choice to drive additional activity and reduce waits for care. However, for targets to better align with a long-term agenda to make care more preventative, integrated and holistic, any additional targets should be based on outcomes rather than outputs (Van Ark 2022).**
- **Devolve rather than hoard target-setting power: centrally set targets encourage systems and providers to look upwards to central government rather than outwards to the communities they serve when making decisions. Where target setting continues to be a lever used in the NHS, more of it should occur at the system rather than the national level.**

Competition and choice are not a silver bullet in driving productivity or quality

Over the past three decades, competition and choice have been seen as key levers to increase access to and the quality of healthcare. Empowered patient choice in healthcare is welcome. People have become used to greater choice in all aspects of their life. The NHS cannot be left behind. Maintaining choice in healthcare is therefore, in part, a question of rights and entitlements in a modern healthcare system.

However, for policymakers that also want to use choice as a lever of reform and improvement, the lessons from the past few decades are more salutary. There is some evidence that competition and choice may play a role in boosting activity in acute settings, particularly where care pathways are relatively straightforward (for instance in the case of elective hip and knee surgery or cataract procedures). But, overall, the evidence is clear that it often comes with downsides – and is not applicable to all settings of care.

Competition and choice are far less effective in stimulating improvement – and can even worsen the quality of care. This is especially true in emergency care settings and primary and community services that support older people and those living with long-term conditions, now the NHS's 'core customers' who account for 70 per cent of all healthcare spending in the latest major study undertaken in 2012 – a share that will have since grown further (Department of Health 2012). In these settings, there is strong evidence that market-based competition can undermine the cooperation and collaboration between providers that is a prerequisite for comprehensive joined-up care.

Relatedly, there is evidence that without stringent regulation, competition can lead to those with the most acute health needs receiving worse access to care – providers have incentives to selectively treat patients who are the least costly and easiest to manage, while avoiding high-risk or complex cases.

Finally, as with any market, for competition to drive more efficient and higher-quality service delivery there must be a broad range of willing providers. As a (necessarily) tightly regulated industry, barriers to new suppliers entering the market are high across the board, particularly in rural areas where exercising choice would involve patients travelling long distances to receive care. The potential for competition and choice to drive improvement is therefore circumscribed by geography as well as setting.

If policymakers seek to use competition and choice, they should:

- **Focus on making choice meaningful: this would involve improving people's access to information on the quality and safety of services – particularly in sectors where there is less routine data collection on key performance metrics, including where NHS services are contracted to other providers. This may also require a more active approach to regulation to ensure that patients can make informed choices across good options.**
- **Understand and act on barriers to patients exercising choice in the current system: including patients not being able to afford to travel for care, having low levels of health literacy, or not understanding which choices are available to them.**
- **Be clear about who choice may benefit and who it leaves behind: pro-choice reforms may drive improvement in high-volume, low-complexity acute settings and in urban areas where patients have a variety of willing local providers to choose between. Choice and competition are far less effective in driving improvements for those living with long-term conditions – the NHS's core customers – and in rural areas where more natural monopolies for care provision exist.**

Regulation can help set the floor, but in its current form it can't raise the ceiling

There is a strong case for investing in capacity to ensure standards are being met in healthcare settings and that patient interest is put at the heart of the system. Where regulation works effectively, it can play an important role in enforcing minimum standards on providers and rooting out poor performance. However, it is more effective in moving services from "awful to adequate" than "good to great" (Barber 2017).

At a fundamental level, the success of regulation relies on the public and service providers having confidence in the regulator. Unfortunately, the government has a difficult inheritance to overcome in this area. A comprehensive review of the Care Quality Commission (CQC) carried out by the now Chair of NHS England in October 2024 found that the regulator had "lost credibility in the health and social care sectors" (Dash 2024) and the health secretary has declared that the regulator is currently not fit for purpose.

Before attempts are made to rethink our approach to healthcare regulation, confidence and trust in the current system must be rebuilt. Fortunately, the CQC's improvement journey has already begun with the appointment of a new senior leadership team and the announcement of immediate measures to clear a large provider registration backlog, increase the frequency of assessments, and resolve long-standing IT issues (Care Quality Commission 2025).

However, looking forward, a new approach to regulation will be needed. The most promising future direction of travel will come from building on potential complementarities between regulation, learning and improvement, and staff and patient engagement.

To build a new approach to regulation, policymakers should do the following.

- **Move away from an inspection-led approach to a continuous improvement approach: the core tenets of this approach would include more systematic real-time data collection and monitoring, developing more opportunities for peer benchmarking, and systematising quality improvement as a core goal of regulation (Bevan et al 2018).**

Balance regulatory powers to 'sanction' and 'incentivise': **while regulators must occasionally use their more stringent intervention powers to guarantee patient safety and mitigate risk, heavy-handed regulation can be a brake on reform. Appropriate use of incentives such as the granting of greater autonomy to high-performing systems and providers and public recognition of achievements should be seen as core features of the regulatory toolkit.**

LESSON 3: A NEW TOOLKIT IS AVAILABLE TO MEET NEW CHALLENGES

Used judiciously, targets, competition and choice, and regulation may have value in shoring up the short-term performance of the NHS, but where government seeks to transform rather than stabilise healthcare services, a new toolkit is necessary. The three additional levers set out in our evidence review – learning and improvement, devolution, and patient and staff engagement – hold great promise in this regard. A comprehensive reform programme would look to use these levers in tandem to drive sustained improvement.

Moving towards this approach requires political courage. The reason that policymakers have historically been more inclined to use 'hard' levers such as target-setting, competition and regulation partially stems from the fact that these levers grant the feeling of greater control over the reform agenda. Retaining a high level of central control may feel especially tempting given the NHS's current performance crisis.

However, in the longer term, a new operating model is required for the NHS – continuous improvement will only occur where systems and providers feel empowered to drive reform rather than react to plans issued from above. Below, we map out what a new approach could look like.

Unlock insights from the frontline for rapid improvement

Decision-making in the NHS often lacks information and insights from those providing care. This leads NHS organisations to set the wrong priorities and miss opportunities to improve. Stronger staff engagement is essential for a responsive and high-performing NHS, but it requires institutional reform and investment.

Most importantly, this requires a true shift to digital: the systematic collection of real-time data for analysis and learning (Hardie et al 2022). Frontline staff, both clinical and non-clinical, must be empowered to use these insights to design and implement changes at the local level which can be tested, refined and optimised to drive continuous improvement.

Hardwiring staff-led learning and improvement into the NHS will also require reforms to *processes* and the underlying *culture* of the system. In the first instance, investment in digital systems, data and analytics will be required to ensure that performance can be better understood, frontline insights can be collected systematically, and improvement can be accurately measured. This will also require a new approach to operational management The evidence is clear that high-quality leadership and management in the NHS delivers better care for patients. Operational staff and analysts must be much more closely embedded with clinical teams to make improvement a shared endeavour.

Culturally, approaches to leadership and management will need to be more permissive and distributed – frontline teams will need to be entrusted with stewarding improvement efforts with senior leaders playing an enabling role.

To drive frontline led improvement, the following steps should be taken:

- **Every NHS trust should develop staff insight pathways for service improvement and establish a permanent trust-wide team of improvement specialists. All staff should have time protected to participate in these schemes. Additionally, NHS Trusts should create 'worker boards', to contribute to corporate governance alongside existing executive boards.**

- **Every Integrated Care System should establish an Improvement Team whose responsibilities include improving resource allocation and shared learning across services (such as acute and community care).**

- **Invest in leadership and data capacity. Alongside refreshing the NHS's long-term clinical workforce plan, the government should issue a long-term plan for the NHS's operational management and data analytics workforce.**

Strengthening the role of patients to drive change

Alongside empowering those working in the system to drive improvement, NHS reform must have an unflinching focus on the end-user – patients themselves. Targeted reforms to strengthen the institutional voice of patients in the NHS and empower them to better manage their health will both be vital to improving care quality and transforming the delivery model.

In the first instance, decision-makers should look to make better use of existing channels for patient participation in transformation programmes, for instance the Healthwatch network and GP patient participation groups (PPGs). Government should use the opportunity provided by the abolition of NHS England and the reconfiguration of central bodies to clearly map out a new architecture for patient engagement.

Moving forward, policymakers should also look at alternative channels to plug patient insights directly into a learning model like that outlined above – patient feedback including routinely collected complaints data should be embedded into discussions on productivity, care quality and access.

Alongside strengthening the institutional voice of patients, changes to the care model should also be central to reform. Much emphasis has been placed on choice as a tool for patient empowerment, but for those patients who account for the bulk of NHS activity and cost – those living with long-term conditions – continuity of care is prized most highly and has the most substantial positive impact. Incentivising continuity of care for those who benefit from it most and developing a comprehensive care offer for those living with long-term conditions should be core pillars for any plans for clinical reform.

To strengthen the role of patients in driving improvement, government should:

- **Drive the 'feedback revolution' in healthcare by creating better mechanisms for patients to share their experience of care in real time. Routine, embedded, live feedback by users of services and frontline staff should increasingly become the norm. This feedback alongside existing data from the NHS's Friends and Family Test and complaints data should be curated into dashboards, to provide a live snapshot of user experience which can inform service design and improvement, as well as informing citizens' use of public services. Data should, ultimately, be publicly available so that people can see the experience of others using the same public service, as well as the responses by service providers (such as updates on service changes as a result of feedback).**

Develop an enhanced service offer for those diagnosed with a long-term condition to reduce long-term costs and improve outcomes. This should start with those diagnosed with long-term conditions co-producing an integrated health and care plan with a healthcare professional. The subsequent service offer would include access to longer consultations in primary care, training or peer support to self-manage health needs, and the offer of a personal health and social care budget.

The government should 'recentralise to decentralise'

The NHS remains one of the most centralised health systems in the developed world (Ham 2022). This has a direct bearing on the levers for reform that policymakers have chosen to pull in recent decades – centralised targets and a top-down approach to regulation have been prioritised over more adaptive approaches to improvement.

Our evidence review suggests that a more decentralised model can help boost the efficiency and productivity of healthcare delivery and help better match services to the needs of local populations. However, changes will be necessary to ensure that a success is made of more comprehensive devolution.

The necessary first steps to reduce the power of central bodies in the healthcare system have already been taken, as government has moved to reduce layers of bureaucracy at the centre. But the abolition of NHS England should be the starting pistol for a more fundamental reset of the NHS's operating model.

In the coming months, difficult decisions will need to be made about what functions need to sit in a smart, strategic centre. There are obvious candidates here – negotiating commercial contracts with the life-sciences industry, curating an effective healthcare data architecture, and optimally distributing funding between regional or local care systems.

In other instances, a mixed approach which marries central standard setting with more local strategy development may be more advantageous – sharing and spreading good practice between NHS organisations, planning and delivering the workforce of the future, rolling out large-scale public health programmes such as vaccination and screening. Other functions that once sat centrally should move to a regional or local level to unlock the strengths of devolution as a reform lever.

Getting devolution right will require matching ambition with resource. Management capacity freed up at the centre should be redistributed to regions and Integrated Care Systems (ICSs). The recently announced efficiency drive in ICSs (West et al 2025) which will see operating budgets cut by 50 per cent, may secure cash savings in the short term. Yet if government wishes to decentralise well, it will have to grow not shrink capacity across systems.

Alongside more effective resourcing of regional and system decision-makers, local autonomy must also be made more meaningful. The centre should avoid being overly prescriptive on process and activity targets, and should instead move towards setting outcome-based targets for systems. Local leaders would be empowered to deliver against them in the ways they see fit. A healthier balance between high-level national priorities and more specific, locally tailored goals will have to emerge. New approaches to target setting will also have to be coupled with more financial freedoms for systems, including choice over how to fund their hospitals and allocate resource to other providers. Given the importance of shifting care into the community, a high-level target to increase the share of resources going to out-of-hospital services could be set centrally with systems free to deliver on this goal in whichever way they see fit.

To decentralise power and build a system-led NHS, policymakers should do the following.

- **Redistribute central staff to ICSs and providers to drive transformation.** Acknowledging that at a subnational level, the NHS is under- rather than over-managed, management capacity should be redistributed from central bodies to NHS systems and provider organisations.
- **Replace the vast majority of targets with a small number of outcome mission metrics.** Set an overarching health mission for ICSs to meet but replace the majority of centrally set targets with a leaner set of 'milestone' metrics to indicate delivery against the mission. These metrics should be codeveloped by ICSs and the centre.
- **Devolve the power to shift resources around the system.** Greater autonomy over resource allocation should be devolved to systems, including over how to finance hospitals, allowing them to shift funding and interventions 'upstream'.

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ANNEX: MODELLING ASSUMPTIONS

This represents outputs from the healthcare funding projections analysis carried out by Lane Clark & Peacock LLP for the Institute of Public Policy Research.

In this analysis, annual costs are projected from a 2023/24 baseline that is set in line with total Department of Health and Social Care net expenditure from operating activities. The projections allow for expected future changes in healthcare utilisation rates, unit costs and population demographics, leveraging data from the ONS, OBR and NHS England. The scenarios outlined in the tables below model the effect of varying the assumptions for future healthcare-related productivity improvements and general population health, with changes in life expectancy and healthy life expectancy used as a proxy for the latter.

The principles of the analysis are consistent with LCP's 2023 healthcare funding projections, previously described (McDonald et al 2023).

This analysis has been produced for IPPR, and LCP accepts no liability towards any other organisations for this analysis.

TABLE A1: SCENARIO SPECIFICATIONS

Scenario	Core assumptions	Total costs in 2029/30	Annual savings by 2029/30	Total costs in 2034/35	Annual savings by 2034/35
Repeating history (baseline)	- ONS projected LE[3] and flat HLE[4] - NHS productivity growth of 0.5% pa	£256bn	-	£342bn	-
Improved productivity	- ONS projected LE and flat HLE - NHS productivity growth of 2% pa	£237bn	£19bn	£294bn	£48bn
Improved prevention	- Halving HLE gap in regions (relative to post-COVID HLE[5]) - NHS productivity growth of 0.5& pa	£254bn	£2bn	£336bn	£6bn
Combined prevention & productivity	- Halving HLE gap in regions - NHS productivity growth of 2% pa	£235bn	£21bn	£289bn	£53bn

3 Comparison of life expectancy estimates with projections, UK and constituent countries (ONS 2025a).

4 Consistent with the trend seen in the 2010s.

5 Post-Covid HLE based on 2021–23 ONS data (61.7 years in England and 64.0 years in the South East, the region with the highest HLE) (see ONS 2024a). In this scenario the average rate of projected growth in national HLE is 0.17 per cent per year.

TABLE A2: PROJECTED HEALTHCARE SPENDING (DHSC NET CASH OUTFLOW FROM OPERATING ACTIVITIES) IN ENGLAND AS A SHARE OF GDP

	Repeating history (baseline)	Combined prevention & productivity
2019/20	7.1%	7.1%
2020/21	10.2%	10.2%
2021/22	9.5%	9.5%
2022/23	8.2%	8.2%
2023/24	8.0%	8.0%
2024/25	8.1%	8.0%
2025/26	8.2%	7.9%
2026/27	8.4%	8.0%
2027/28	8.6%	8.1%
2028/29	8.7%	8.1%
2029/30	8.8%	8.1%
2030/31	9.0%	8.1%
2031/32	9.1%	8.1%
2032/33	9.3%	8.1%
2033/34	9.4%	8.1%
2034/35	9.6%	8.1%

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