DEMOS

REFORM FAILURE

LESSONS FROM THE HISTORY OF HEALTH SERVICE REFORMS – AND HOW NOT TO REPEAT THEM

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All arguments represented here are our own and do not necessarily represent the exact views of our partners or contributors.

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ABOUT THIS PAPER

This paper is part of Demos's Powering Public Service Reform programme.

Building on the success of the Future Public Services Taskforce, **Powering Public Service Reform** aims to understand and overcome the deep, systemic barriers that hold back genuine reform.

Despite a growing consensus that reform should focus on services that are preventative, joined-up, and people-centred, too often promising ideas falter once they encounter the machinery of Whitehall. Risk aversion, siloed structures, and short-termism remain powerful forces that distort or derail innovation.

The programme combines research, convening and practical experimentation across five core workstreams:

- **Culture**: tackling the norms of hierarchy, central control and risk aversion that limit innovation.
- **Accountability**: reshaping systems that currently reward compliance and outputs over outcomes and learning.
- **Funding**: shifting fiscal frameworks that drive short-term crisis management instead of long-term prevention.
- **Digital enablement**: ensuring technology is used to transform services, not entrench old ways of working or simply to cut costs.
- **Communications and narrative**: finding more accessible, resonant ways to make the case for reform with political insiders, to enable the proliferation of ideas across the country, and to engage the public in the process.

At its heart, Powering Public Service Reform is about focusing relentlessly on changing the system – shining a light on why reforms stall, developing and testing solutions to unlock progress, and building a coalition of reformers across government and beyond to make them a reality.

EXECUTIVE SUMMARY

The health system provides a valuable lens for understanding public service reform. As the UK's most visible and politically significant public service, the NHS is often treated as a measure of government performance, while its constant balancing of prevention and acute care highlights the core trade-offs of reform. Decades of repeated restructuring alongside sustained demand pressures make it a rigorous test case for wider reform models.

This research analysed three major waves of NHS reform since 2000 through the lens of Demos's 10 Principles for Liberated Public Services, a framework that we are exploring the use of as a diagnostic tool for public service reform agendas. The principles provide a structured way to assess both the ambition of reforms – what they set out to achieve – and the reality of their implementation – what they delivered in practice.

The three reforms analysed are:

1. The NHS Plan (2000)
2. The Health and Social Care Act (2012) – referred throughout as 'the Lansley Reforms'
3. The 10 Year Health Plan (2025).

Our analysis interrogated both stated ambition – the vision for reform – and the implementation, how reforms were translated into reality. In synthesising themes, we explored why this translation so often falls short, identifying practical lessons for the implementation of the 10 Year Health Plan, and, more broadly, insights into the systemic changes required to support other reforming agendas to succeed.

The exercise provides valuable insight into the evolution of reform thinking itself. Across the reforms examined, there is evidence of a paradigmatic shift towards the language and intent of more liberated, relational public services. Yet at the same time, the analysis reveals the extent to which delivery is far more challenging than articulation.

Using Demos's 'Principles of Liberated Public Services' as a framework, the analysis demonstrates stark differences in reforming ambition and implementation. The implementation of the 2000 and 2012 reforms paints a picture of stubborn systemic retreat to central command, siloed thinking and a failure – or inability – to empower patients and professionals.

That implementation has consistently fallen short of the reforming ambition is not due to a lack of vision. Subsequent reforms have faltered on contact with a system that disincentivises collaboration, innovation and integration: the best laid relational reforms have failed due to their failure to reshape the system itself.

In particular, the analysis reveals relationships between the centre and local commissioners and providers that remain characterised by control, performance management, and risk aversion. These features work directly against the conditions required for integration, prevention, and locally responsive innovation. As a result, even reforms explicitly designed to empower the frontline and enable collaboration have often reproduced the very dynamics they sought to escape.

This misalignment has had profound and unintended consequences. The centralised targets of the NHS Plan drove hugely successful improvements in specific metrics, but at the cost of distorting behaviour: for example, reports of hospitals removing the wheels from hospital trolleys so that they may be classified as 'beds' and thus meet four hour A&E targets[1] and the 'right drift', an increase in funding for acute care.[2] Attempts at decentralisation in the 2012 reforms created fragmentation and complexity without delivering genuine autonomy.[3] Efforts to promote integration have been undermined by competitive incentives and rigid accountability structures.

The 10 Year Health Plan has been heralded even by its own political architects as a point of no return for the NHS. The imperative to learn lessons from previous reforms could not be more pressing. The Plan – with the Neighbourhood Health agenda, the focus on prevention and digital enablement – represents the clearest articulation yet of a shift towards a more preventative, integrated and person-centred model of care. But without fundamental changes to how the system is governed, funded and held to account, there is a significant risk that these ambitions will once again be diluted in practice. We conclude with 5 recommendations to support the implementation of the current set of reforms:

RECOMMENDATIONS

1. *A Cabinet Office 'Public Service Reform Board', chaired by the Chief Secretary to the Prime Minister, to be established to coordinate across overlapping public service reform agendas, identify potential duplication, areas for collaboration and cross-pollinate learning.*

2. *Involvement of the centre in poorly performing providers should avoid simply implementing 'failure regimes', but use the intervention to implement a 'supported innovation' model.*

3. *The focus would not simply be improving performance to meet an agreed baseline, but to embed the skills and capacity for these providers to collaborate, innovate and learn from highly performing areas who are already benefiting from 'earned autonomy'. In this way, the benefits of innovation are not just limited to the most highly performing providers.*

4. *Building on the Medium Term Planning Framework (2026/27-2028/29), DHSC should require and support ICBs to undertake an explicit prioritisation exercise to identify a small number of locally determined strategic priorities.*

   These priorities should be accompanied by permissive national guidance to enable the sequencing and phasing of all other activity within the Medium Term Planning Framework, thereby ensuring realism in delivery and coherence between national priorities and local system capacity.

1 https://pmc.ncbi.nlm.nih.gov/articles/PMC1126565/#:~:text=Accident%20and%20emergency%20(A&E)%20departments,'%E2%80%9D
2 https://assets.publishing.service.gov.uk/media/6a05a27e97000cb6073e4dd8/lord-darzi-independent-investigation-of-the-national-health-service-in-england-updated-14-May-2026.pdf
3 chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.instituteforgovernment.org.uk/sites/default/files/publications/Never%20again_0.pdf

5. *The Health Bill 2026 should mandate citizens panels 'Neighbourhood Boards' to be established as part of every ICB, with clear roles and responsibilities in terms of ICB decision-making.*

   Learning from Neighbourhood Boards developed as part of the Pride in Place Programme can inform the successful establishment and development of these boards. Programme can inform the successful establishment and development of these boards.

Three lessons for a reforming government

At the time of writing it is anticipated that Andy Burnham will be the next prime minister, promising the most ambitious devolution reform agenda in history. Our analysis provides some timely lessons for the devolution agenda.

First, devolution embeds reform but does not deliver it. This analysis highlights that reform often fails when the centre devolves in name only and retains substantive control. A reforming agenda driven by a desire to move power out of Whitehall is welcomed – but this cannot just be a shift from central institutions to local ones such as a combined authority. It must also involve devolving power to the frontline and to citizens and communities as well. And in turn moving away from command and control models of governance to genuinely collaborative ones.

Second, delivering on the reforming ambition requires tackling the current institutional machinery. This report sets out how, despite the 10 Year Plan being framed as critical to a government mission, it has not been accompanied by the relevant supporting infrastructure. In the absence of this, restructures and financial recovery have crowded out strategic reform and accountability remains fragmented across numerous institutions. Developing units such as the Cabinet Office Public Service Reform board, would help ensure the broader apparatus of the state is brought to bear in ways that enable, rather than stifle the reforming ambition.

Third, the approach here is a blueprint that can be applied to evaluate and assure broader public service reform. An incoming administration will not be inheriting a blank slate. It is vital those stepping into power have the tools and processes available to quickly get to grips with the full gamut of reforming activity taking place across the state. Many will lead to better public service, but others are simply modernising flawed systems, leaving public services to be something a citizen endures, rather than enjoys.

SECTION 1
NHS REFORM – A SHORT ACCOUNT OF A LONG HISTORY

The implementation gap in relational reform

Across public services there is now a growing consensus about the direction reform should take – politicians, policymakers, practitioners and think tanks are increasingly converging on a model of services that are preventative, integrated and person-centred. Demos's 10 Principles for Liberated Public Services articulate this vision in full.[4] At their core, these principles go beyond describing what reforms public services need, to describing changes in the nature of relationships within and across the system.

Yet while this vision is now widely understood, successive waves of public service reform have demonstrated that delivery is far harder than articulation. Reform programmes frequently begin with compelling diagnoses and ambitious rhetoric, only to falter as they encounter the institutional realities of government: entrenched cultures, misaligned incentives, and systems of accountability that reward compliance over learning.

"Relational Reform"

For the purposes of this paper, 'relational reform' refers to a shift in public services toward relationship-based, locally empowered, and preventative systems that enable collaboration between the state and citizens, rather than top-down, transactional delivery.

Initiatives in places such as Wigan Council, Camden Council, and the Bromley by Bow Centre demonstrate how relational, locally embedded approaches – built on trust, continuity, and holistic support – can improve outcomes and help reduce long-term demand.

Understanding health as a test case for wider public service reform

Nowhere is this tension more evident than in the health system. The National Health Service is arguably the most high profile, politically salient and widely relied upon public service. 'Waiting times', 'A&E overwhelm', 'GP access' have all become shorthand for whether the government

4 https://demos.co.uk/wp-content/uploads/2024/05/Taskforce-Vision-Paper_May.pdf

is delivering on its promises (which typically relate to meeting acute need rather than systemic reform) – and, more broadly, a proxy measure of the state's effectiveness in managing public services.

Health is also distinctive in that the trade-offs between prevention and treatment are especially visible and acute: decisions about where to allocate resources – towards early intervention and public health, or towards acute and emergency care – play out in real time, often under intense political and public scrutiny.

It is also the most intensively and continuously reformed public service, with at least six major waves of structural change and numerous additional reorganisations since its creation 70 years ago.[5] At the same time, the system operates under persistently high demand pressures, making it an effective stress test for reform models and their ability to deliver under strain.

Combined with a comparatively well-developed evidence base on system reform, this makes the health service an especially useful test case. This paper offers a deep dive on health service reform as the ideal lens for understanding the systemic drivers and blockers of public service transformation.

At the time of writing, Andy Burnham is expected to become the next prime minister, and has pledged the most ambitious devolution agenda in a generation, that moves power out of Whitehall and puts it closer to citizens. An incoming administration will be stepping into a vastly complex reforming agenda. They will need to quickly grapple with what is working and what isn't. The history of NHS reform can provide an instructive lesson to those stepping in to power.

Demos's 10 Principles of Liberated Public Services

Demos's 10 Principles for Liberated Public Services[6] (2024) provide a clear articulation of the emerging consensus around relational reform and the operating principles that should animate public services. They set out a vision for public services that are built on trust, shared responsibility and long-term outcomes, rather than transactional models driven by targets, compliance and short-term performance management. We are exploring the use of the principles as a diagnostic tool to test the ambitions of public service reform agendas.

Crucially, the principles do not simply describe what good services look like; they also imply a different set of system conditions. For example, devolution of design of services (Principle 3), requires associated devolution of funding, and governance mechanisms that support sufficient transparency and accountability for local decision-making, without reverting to command and control.[7] Likewise, collaboration across service siloes or between providers (Principles 4 and 6) may require a different set of procurement rules than those which sought to use competition as a lever to drive up the quality of services.[8]

The principles are organised around three interrelated shifts:

- **The Centre**: redefining the relationship between central government and frontline services, moving from command-and-control towards mission-setting, enabling and stewardship.
- **Services**: reshaping how different parts of the system interact, with a focus on integration, collaboration and shared learning rather than competition and fragmentation.

5 https://www.nuffieldtrust.org.uk/features/nhs-reform-timeline
6 https://demos.co.uk/research/liberated-public-services-a-new-vision-for-citizens-professionals-and-policy-makers/
7 OECD. (2019). *Making decentralisation work: A handbook for policy-makers*. OECD Publishing.
8 House of Commons Health and Social Care Committee. (2019). *The government's proposals for changes to NHS legislation (HC 2000)*. UK Parliament.

- **Citizens**: transforming the role of the public from passive recipients of services to active participants in shaping their design and delivery.

The principles as an analytical framework

In this paper, the 10 Principles are used as a framework for analysing three major NHS reforms. They provide a structured way to assess both the ambition of reforms – what they set out to achieve – and the reality of their implementation – what they delivered in practice.

TABLE 1
THE PRINCIPLES OF LIBERATED PUBLIC SERVICES

	PRINCIPLE	MEANING	RATIONALE
THE CENTRE A new relationship between central government and the delivery of public services	**Principle 1**: Mission-driven public services	National politicians set broad missions, giving directionality to public service ecosystem	Shift from target culture to liberate professionals, but still track impact of services through a focus on shared outcomes are taken
	Principle 2: Respect for public service professionals	Financial and non-financial steps to ensure public service professionals feel respected	Unlock 'intrinsic motivation' of public service professionals
	Principle 3: Devolution and alignment	Devolve design and delivery responsibilities to the lowest appropriate level - but crucially ensure this is aligned geographically	Unlock service integration (see below) To encourage experimentation and innovation, shaped around local and citizen need
SERVICES A new relationship between different place-based public services	**Principle 4**: Service integration	Services are designed around the individual, rather than structured around delivery siloes	Complex systems affect people's lives, meaning siloed delivery fails
	Principle 5: Peer-to-peer learning	Insights and learnings are shared between different services operating in a place, and where relevant shared nationally	The adaptive nature of complexity means services must experiment and innovate; it's crucial the lessons from these innovations are effectively disseminated
	Principle 6: Collaboration between different providers	Providers work together and join up, rather than 'competing' for 'customers'	Competition between different providers produces undesirable consequences Supports service integration (see above)

	Principle 7: Join-up public services with wider social and economic policy	Integration and alignment of public services with wider social and economic policy	Foundational factors drive demands for public services; they must work in concert together
CITIZENS A new relationships between citizens and public service professionals	**Principle 8**: Professionals are freed to experiment in line with local variation and citizen need	Shift from compliance-intensive regimes to looser frameworks which support professional liberation	Experimentation and innovation of service design and delivery, to suit citizen and local needs, drives improvement in services
	Principle 9: Strengths-based approach	A shift from 'deficit model' approach which limits effectiveness of services	Unlocking citizen resources to support service delivery
	Principle 10: Services designed with citizens, through co-production and participation	Co-production is the involvement of service users in the design and delivery of public services	Unlocking citizen resources to support service delivery Alternative to market mechanism to drive service improvements

Methodology: NHS reform through the lens of Demos's 10 Principles of Liberated Public Services

This paper was informed by a literature review of three major health reforms to the NHS in England since 2000:

1. "Plan for Investment, Plan for Reform": The NHS Plan (2000)
2. "Equity and Excellence: Liberating the NHS": The Health and Social Care Act (2012)
3. "Fit for the Future: 10 Year Health Plan for England" (2025)

Each set of reforms was analysed with respect to Demos's 10 Principles for Liberated Public Services, seeking evidence for the extent to which the reforms embodied the principles in ambition and the extent to which implementation delivered against this ambition. Where the reforms do not speak specifically or with substance to a principle, this is noted. A rating of red, amber or green was allocated based on:

- Analysis of the language used in reform proposals, legislation, policy and/or guidance
- Government communications and positioning of the reforms (e.g. key speeches)
- Contemporaneous debate and reaction to the reforms
- Evidence relating to the implementation and impact of the reforms and the extent to which they achieved the spirit/reality of the 10 Principles of Liberated Public Services.

A roundtable with health policy experts from the Department of Health and Social Care, national health charities, representatives of health care professionals, pharmaceutical industry and think tanks was held to discuss the analysis and inform policy development. Recommendations are made for the implementation of the 10 Year NHS Plan, drawing on insights and learning from previous reforming attempts.

A note on the reforms selected:

The NHS has been subject to almost continuous reform since its inception. This has ranged from the large scale and fundamental, such as the three reforms examined in this paper, to incremental, focussed on the design, commissioning or delivery of a particular service, or the evolutionary, such as the evolution of Integrated Care Boards from the mid-2010's until now. The three reforms explored in this paper, therefore, are not intended to be representative of this full range of reforming agendas. Instead they have been selected to represent major reforming moments within the last 25 years and varied political and economic contexts.

A note on the scope of the analysis:

Clearly, no reform occurs in a vacuum, and relevant political, economic, and social context is referenced where necessary, for example the impact of austerity on the 2012 reforms. However, this analysis does not offer a comprehensive exploration of the relationship between these broader contextual factors and the implementation of the reforms, focusing instead on the stated ambitions of the reforms and an evaluation of their impact, and the interaction between the two.

Table 2, on page 15, contains the 'scorecard' for each set of reforms, demonstrating a shift in ambition towards liberated principles across the three NHS restructures (as evidenced by the shift from red to green). However, the scorecard also demonstrates that each of the two previous reform agendas fell short of ambitions in implementation. The analysis of each reforming agenda is explored in more detail below.

SECTION 2

THE NHS PLAN 2000 ("PLAN FOR INVESTMENT, PLAN FOR REFORM")

"The centre will do what it must do: set standards, monitor performance, support modernisation, put in place a proper system of inspection, and, when necessary, correct failure."

– Prime Minister Tony Blair, Hansard 2000

Overview & Rationale

The NHS Plan (2000) was a landmark 10-year modernisation strategy responding to what then Prime Minister Blair called a "clapped out" service after decades of chronic underinvestment. The NHS Plan was succeeded by – and delivered through – a raft of accompanying policies and reforms, including but not limited to:

- Health and Social Care Act 2001. National Health Service Reform and Health Care Professions Act 2002, Health and Social Care (Community Health and Standards) Act 2003 and the Health Act 2006 – included public health measures (e.g. smoking ban) and aspects of service reform.
- Payment by Results (2003) – a tariff-based payment system for acute services
- Agenda for Change (2004) – an overhaul of terms and conditions for NHS staff

Its central proposition was a deal: unprecedented sustained funding, delivering on the Labour commitment to match European average health spending, in return for radical structural reform. Public frustration had peaked over wait times exceeding 18 months, deteriorating infrastructure, and a "postcode lottery" of care standards.

The underlying rationale was that the NHS's founding structures were no longer responsive to rising patient expectations or the complexity of modern disease and that investment without reform would simply entrench failure.

The Plan aimed to move the NHS from its 1948 hierarchical model and intended to improve patient experience – as defined by ease of access and customer service – backed by concrete

commitments: 7,500 more consultants, 20,000 more nurses, 100 new hospitals, maximum waiting times of four hours in A&E and six months for operations, and the creation of Primary Care Trusts to devolve commissioning.

Impact and legacy

The immediate impact was dramatic. Waiting times fell sharply, with the landmark 18 week referral to treatment target achieved by 2008. Clinical outcomes improved substantially, with significant reductions in cancer and cardiovascular mortality over the following decade.

The workforce expanded by 307,000 and 3,000 GP premises were modernised. Public satisfaction peaked at a record 70% in 2010.

Yet the long term legacy is more contested. Heavy reliance on PFI saddled NHS trusts with repayment liabilities running into tens of billions over several decades. The rigid target culture left a mixed inheritance, incentivising gaming where staff prioritised metrics over holistic care, a failing most tragically exposed by the Mid Staffordshire scandal.

TABLE 2
SCORECARD OVERVIEW: THE NHS PLAN 2000

	LIBERATED PUBLIC SERVICES SCORE CARD: The NHS Plan (2000)	AMBITION	REALITY
THE CENTRE: A NEW RELATIONSHIP BETWEEN CENTRAL GOVERNMENT AND THE DELIVERY OF PUBLIC SERVICES	1. Mission-driven public services		
	2. Respect and autonomy for public service professionals		
	3. Devolution and alignment		
SERVICES: A NEW RELATIONSHIP BETWEEN DIFFERENT PLACE-BASED PUBLIC SERVICES	4. Service integration		
	5. Peer-to-peer learning		
	6. Collaboration between different providers		
	7. Join-up public services with wider social and economic policy		
CITIZENS: A NEW RELATIONSHIP BETWEEN CITIZENS AND PUBLIC SERVICE PROFESSIONALS	8. Professionals are freed to experiment in line with local variation and citizen need		
	9. Strengths-based approach		
	10. Services designed with citizens, through co-production and participation		

TABLE 3
IN DEPTH ANALYSIS: THE NHS PLAN 2000

THE CENTRE: A NEW RELATIONSHIP BETWEEN CENTRAL GOVERNMENT AND THE DELIVERY OF PUBLIC SERVICES	
1. Mission-driven public services	**Focus on funding, performance and efficiency, driven through tightly managed central targets, took precedence over overarching outcome goals.** The Plan introduced radical reform to what the then Prime Minister, Tony Blair, referred to as a 'clapped out' service. Yet both the analysis of the problems facing the NHS, the reforming approach, and the implementation decidedly embodied a New Public Management approach driven by targets and transfer of resource. NHS reform as a 'technological' mission: Mission-driven government is designed to tackle so called 'wicked challenges' – complex, with diffuse causes and multiple solutions.[9]
	On the contrary, many of the challenges to be addressed by the 2000 reforms – crumbling NHS premises, poor quality food, waiting times, cleanliness – were identified and defined in discrete, measurable terms. These challenges, whilst daunting in scale (e.g. waiting times of over 18 months) leant themselves to numerical targets, and could be, as the success of the reforms demonstrated, successfully tackled through large injections of cash, skills and capacity (e.g. 7500 new consultants). In this way, the NHS Plan embodied a more traditional 'technological' mission approach (such as the mission to land a person on the moon) – clearly defined, and addressed using resource, targets and performance management.[10] **Centrally-driven**: Whitehall maintained tight control through a "command and control" model of national targets, including maximum four-hour waits in A&E and specific milestones for cancer and heart disease. New systems of performance management for providers penalised poor performance with greater central control, limiting the scope of local commissioners and providers to innovate. **Focus on targets, not outcomes**: This approach resulted in significant reductions in waiting times, cancer survival rates, and patient satisfaction with the NHS,[11] but also introduced perverse incentives into the system and focussed attention on narrow measures of success. Payment by Results, which paid NHS providers for achieving specific targets, prompted behaviour such as 'cream skimming' (picking the easiest cases), rather than motivating a holistic approach to achieving 'North Star' type outcomes (e.g. improvements in population health outcomes).

9 Department of Health. (2005). *Commissioning a patient-led NHS*. The Stationery Office. https://webarchive.nationalarchives.gov.uk/ukgwa/20091106065608/http://dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4116717.pdf
10 University College London. (n.d.). *Missions: A beginner's guide* (IIPP Policy Brief 09). https://www.ucl.ac.uk/bartlett/sites/bartlett/files/iipp_policy_brief_09_missions_a_beginners_guide.pdf
11 John Appleby, Nina Hemmings, Jessica Morris, & Laura Schlepper. (2022). *Public satisfaction with the NHS and social care in 2021*. The King's Fund. https://www.kingsfund.org.uk/insight-and-analysis/reports/public-satisfaction-nhs-social-care-2021

2. Respect and autonomy for public service professionals	The Plan specifically addressed issues of workforce challenges and staff morale, but also introduced centrally-driven and stringent accountability regimes. The latter went some to addressing the 'postcode lottery', but at the same time undermined the autonomy of local professionals and services to innovate and respond to local need. **Staff morale**: The Plan included measures to specifically address low staff morale, such as the Improving Working Lives initiatives, and practical support such as 100 on-site nurseries for the children of NHS staff and funding for individual professional development.
	Professional autonomy: The Plan introduced expansion of professional responsibilities of nursing staff (e.g. prescribing and referrals), a move welcomed by the nursing profession, but also accompanied by heated debates between different professional bodies about risk management and delineation between different clinical and medical roles. And in signalling the re-negotiation of both the consultant and GP contracts, the plan also introduced complex and fraught negotiations with the medical profession around working hours, professional development and changes to the GP practice contracting model. The new contracts involved significant pay increases for both consultants and GPs, and enabled GPs to opt-out of out of hours provision – a move welcomed by the profession – but also undermined professional autonomy through the introduction of target based incentives (e.g. the Quality and Outcomes Framework). **Accountability**: The focus on 'quality' and nationally agreed standards of care, e.g. through the establishment of the National Institute for Clinical Excellence (now National Institute for Health and Care Excellence), played an important role in reducing postcode lotteries in access to services and treatments.[12] However, the introduction of new regulatory frameworks (e.g. the establishment of 'Monitor', the regulator for foundation trusts) stringent new inspection regimes, and processes for management of failing providers, were criticised for being punitive, disempowering for managers and clinical professionals, and failing to take into account local priorities and challenges.[13]

12 House of Commons Health Committee. (2008). *Foundation trusts and Monitor: Sixth report of session 2007–08* (HC 27-I). The Stationery Office. https://publications.parliament.uk/pa/cm200708/cmselect/cmhealth/27/27.pdf

13 Altman, D. G., Moher, D., Schulz, K. F., & Devereaux, P. J. (2001). *The revised CONSORT statement for reporting randomized trials: Explanation and elaboration. Annals of Internal Medicine*, 134(8), 663–694. https://pmc.ncbi.nlm.nih.gov/articles/PMC1126835/

3. Devolution and alignment	**The NHS Plan created a strong network of local NHS bodies, yet commissioning policy from the centre remained directive and the emphasis was on consistency of provision across different localities, rather than place-based innovation.** 28 Strategic Health Authorities (SHAs) were established to enable innovation and facilitate a strategic approach across primary, secondary and tertiary care in a region. However, their responsibilities also encompassed performance management to ensure 'uniformly excellent frontline NHS organisations',[14] which entrenched a firmly hierarchical relationship between SHAs, PCTs and providers organisations.[15] Primary Care Trusts (PCTs) replaced Primary Care Groups (sub-committees of local Health Boards) and were freestanding local commissioner/provider bodies. PCTs were eventually responsible for 80% of NHS spending and over 120 statutory functions,[16] a significant shift towards devolution of decision-making. However, simultaneously, commissioning policy from the centre remained directive and centred on targets,[17] e.g. mandating that patients should be offered a choice of 5 providers for elective care.[18] In this way, whilst many PCTs developed into strong and effective local commissioning bodies, the system was still defined by hierarchy and the emphasis was on uniformity of provision, rather than local innovation.
SERVICES: A NEW RELATIONSHIP BETWEEN DIFFERENT PLACE-BASED PUBLIC SERVICES	
4. Service integration	**The establishment of PCTs was a potentially positive step towards enabling greater join up between services, but 'choice and competition', the introduction of the purchaser-provider split and increasing stringent requirements around public sector procurement acted as strong disincentives for integration.** **The purchaser-provider split**: The 'purchaser/provider' split (2005) required separation between PCT commissioner and provider functions. Despite the label, complexity around the definitions of 'purchaser' vs 'provider' and government back and forth on the policy created confusion, and ultimately risk aversion towards integration and pooled budgets. **Procurement policy**: EU procurement law and domestic legislation[19] meant there was more pressure for commissioners to justify tendering processes and contracting decisions, and these new – and for the health

14 Department of Health. (2000). *The NHS Plan: A plan for investment, a plan for reform*. The Stationery Office. https://webarchive.nationalarchives.gov.uk/ukgwa/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4076522.pdf

15 Edwards, N. (2020). *Strategic health authorities and regions*. Nuffield Trust. https://www.nuffieldtrust.org.uk/sites/default/files/2020-07/1593704531_strategic-health-authorities-and-regions-final.pdf

16 Department of Health. (2005). *Commissioning a patient-led NHS*. The Stationery Office. https://webarchive.nationalarchives.gov.uk/ukgwa/20091106065608/http://dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4116717.pdf

17 NHS Confederation. (2011). *The legacy of primary care trusts*. https://www.nhsconfed.org/system/files/2021-07/The_legacy_of_PCTs.pdf

18 Department of Health. (2005). *Commissioning a patient-led NHS*. The Stationery Office. https://webarchive.nationalarchives.gov.uk/ukgwa/20091106065608/http://dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4116717.pdf

19 Public Contracts Regulations 2006. (2006). *The Public Contracts Regulations 2006* (SI 2006/5). The Stationery Office. https://www.legislation.gov.uk/uksi/2006/5/contents/made

	service, unchartered – waters, led to more short-termist contracting and competition, rather than integration, between local providers (e.g. statutory and civil society providers). **Fragmented provider landscape**: Likewise, the establishment of NHS Foundation Trusts reinforced the dividing lines between secondary, primary and community care. The focus on performance management, inspection and harsh sanctions for failure contributed to risk-aversion and disincentivised pooling of budgets and integration. 'Choice and competition' was the context for all these structural changes. Alongside the introduction of patient choice of provider, changes to NHS commissioning and contracts introduced much more fragmentation of the provider landscape. For example, the introduction of the 'Alternative Provider of Medical Services' contract in 2004 for the first time enabled non-GPs to hold contracts for general practice services.
5. Peer-to-peer learning	**Peer-to-peer learning, or the establishment of communities of practice, were not addressed specifically in the reforms.** Some have argued that the focus on competition, and the greater presence of private provision of NHS services, undermined collaboration between providers.[20]
6. Collaboration between different providers	See Principle 4: Service integration
7. Join-up public services with wider social and economic policy	The NHS Plan was extremely light on commitments to public health, health inequalities or social determinants of health, instead focussed on structures and competition as a route to improving outcomes.
CITIZENS: A NEW RELATIONSHIP BETWEEN CITIZENS AND PUBLIC SERVICE PROFESSIONALS	
8. Professionals are freed to experiment in line with local variation and citizen need	See Principle 3: Devolution and alignment

20 Jones, B. (2024, December 13). *Competition vs collaboration: Will an NHS league table drive improvement?* The Health Foundation. https://www.health.org.uk/features-and-opinion/blogs/competition-vs-collaboration-will-an-nhs-league-table-drive-improvement

9. Strengths-based approach	**The focus in the NHS Plan was 'patient centredness', but this was defined predominately in operational terms, measured by improvements in patient experience.** For example, reforms focussed on improving reduced waiting times, more convenient appointment times, increasing patient involvement in decision-making about their care (a move "from a service that does things to patients to one which works with patients")[21] and increasing feedback routes for patients. In this model, the patient is positioned as 'consumer' of health services, and the emphasis is on a smooth customer journey. The Demos conception of a 'strengths-based approach' to public services defines the goal of services not to address specific deficits in a person's life, but to take a holistic and outcomes focussed approach.[22] In this model, service users are experts in their condition and needs and partners in decision-making. The NHS Plan's focus on 'patient-centredness' falls short of this
10. Services designed with citizens, through co-production and participation	**Co-production and participation did not feature in the Plan. However, as a precursor to citizen involvement in decision-making, the Plan introduced a focus on patient experience as a measure of performance.** This included the introduction of the largest patient feedback survey in Europe, and established new patient bodies (Patient Advisory Services and Patient Forums) to advise, support and represent patient interests.[23]

The Liberated verdict

The NHS Plan 2000 applied New Public Management to the health service – a centralised, target-driven model of reform, built upon national targets, standardisation, and rigorous performance management – rather than a genuinely mission-driven or locally adaptive approach to public service transformation.

The patient was positioned as a consumer of a more streamlined and effective service, not as a co-producer of their own care; professionals were furnished with greater resources, but were disciplined through firm targets; local commissioners were ostensibly empowered, though they operated within a framework of national directives and uniform standards.

On its own terms, it was largely successful: waiting times fell, mortality from major conditions improved, and public satisfaction with the NHS reached its peak. The reforms were effective in addressing discrete, measurable system deficiencies, but fell short of delivering more holistic, integrated, and participatory transformation of health and care services.

21 Department of Health. (2000). *The NHS Plan: A plan for investment, a plan for reform.* The Stationery Office. https://webarchive.nationalarchives.gov.uk/ukgwa/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4002960

22 Glover, B. (2024, May). *Liberated public services: A new vision for citizens, professionals and policymakers.* Demos. https://demos.co.uk/wp-content/uploads/2024/05/Taskforce-Vision-Paper_May.pdf

23 Department of Health. (2010). *Review of developments in the UK National Health Service.* The Stationery Office. https://assets.publishing.service.gov.uk/media/57a08d1940f0b6497400164c/Review-of-developments-in-the-UK-NHS.pdf

SECTION 3

"EQUITY AND EXCELLENCE: LIBERATING THE NHS": THE HEALTH AND SOCIAL CARE ACT (2012), COALITION GOVERNMENT

"It was no accident that the White Paper setting out the philosophy for the Bill was called Liberating the NHS. We should not be timid in allowing liberation: indeed, I think we should encourage it."

– Secretary of State Andrew Lansley
House of Lords Health and Social Care Bill debate, 2011[24]

Overview and rationale

The Health and Social Care Act 2012, commonly known as the Lansley Reforms, was the most radical structural reform of the NHS since its founding. Its central aim was to "liberate" the service by replacing central management with GP-led commissioning and legislatively mandated competition. The rationale held that clinically led commissioning would be more responsive to local needs than managerial structures, and that competition between providers would drive efficiency.

Politically, it emerged from a Coalition government that had pledged "no more top-down reorganisations" before launching precisely that. The Act introduced a complex web of new commissioning structures. These included the – initially, extremely – hyper-local Clinical Commissioning Groups and an often counter-intuitive division of commissioning responsibilities between different statutory structures (e.g. sexual health to local authorities).

The emphasis was on 'liberation' and empowering front-line clinicians, to the extent that the initial call to action for GPs was to self-organise into clinical commissioning groups: a chaotic first phase of structural reforms that were to prove highly costly (to the tune of £1.5bn-£4bn,

24 Andrew Lansley. (2011, November 9). *Health and Social Care Bill debate*. UK Parliament, House of Lords, Hansard, vol. 732, col. 249. https://hansard.parliament.uk

depending on the analysis used).[25, 26]

Impact and legacy

The Lansley reforms embodied key principles of a liberated public services in ambition: empowerment of frontline professionals, reduction of bureaucracy, local determination. Yet the implementation introduced years of preoccupation with reorganising structures, funding flows and accountability mechanisms that distracted from service reform. Rather than liberating the service, it created a suffocating contractual bureaucracy: a typical CCG managed over 200 separate legal contracts with other NHS bodies, while rigid competition and procurement rules actively impeded the cross-sector collaboration the system desperately needed. NHS performance declined markedly in the years that followed, with constitutional targets for A&E, cancer treatment and elective care not consistently met since. The architecture proved so unworkable that the NHS spent the subsequent decade constructing workarounds, first Sustainability and Transformation Partnerships, then Integrated Care Systems, to bypass the legislative framework it was nominally operating under. The reorganisation consumed leadership attention and political capital at precisely the moment when austerity and rising demand required both.

TABLE 4

SCORECARD OVERVIEW: EQUITY AND EXCELLENCE (2012)

	LIBERATED PUBLIC SERVICES SCORE CARD: Equity and Excellence (2012)	**AMBITION**	**REALITY**
THE CENTRE: A NEW RELATIONSHIP BETWEEN CENTRAL GOVERNMENT AND THE DELIVERY OF PUBLIC SERVICES	1. Mission-driven public services		
	2. Respect and autonomy for public service professionals		
	3. Devolution and alignment		
SERVICES: A NEW RELATIONSHIP BETWEEN DIFFERENT PLACE-BASED PUBLIC SERVICES	4. Service integration		
	5. Peer-to-peer learning		
	6. Collaboration between different providers		
	7. Join-up public services with wider social and economic policy		
CITIZENS: A NEW RELATIONSHIP BETWEEN CITIZENS AND PUBLIC SERVICE PROFESSIONALS	8. Professionals are freed to experiment in line with local variation and citizen need		
	9. Strengths-based approach		
	10. Services designed with citizens, through co-production and participation		

25 Patrick Dunleavy. (2012). *With a likely cost of £4 billion, the Health and Social Care Bill has all the hallmarks of an avoidable policy fiasco.* LSE British Politics and Policy Blog.

26 Full Fact. (2017). *How much will NHS reorganisation cost?* https://fullfact.org/news/how-much-will-nhs-reorganisation-cost/

TABLE 5
IN DEPTH ANALYSIS: EQUITY AND EXCELLENCE (2012)

THE CENTRE: A NEW RELATIONSHIP BETWEEN CENTRAL GOVERNMENT AND THE DELIVERY OF PUBLIC SERVICES	
1. Mission-driven public services	**The overarching aim of the Lansley Reforms – to liberate NHS from political interference and bureaucracy – was 'mission-esque' in nature: a long-term, North star goal. Yet 'local determination' came at the cost of the clear national leadership required for successful mission-driven approaches.** On paper, the reforms embodied 'mission-driven public service', with their focus on clinical outcomes, not process targets, the removal of all targets 'with no clinical justification'[27], and putting clinicians at the helm of commissioning through the establishment of Clinical Commissioning Groups. Yet the central focus on local empowerment and determination led to enormously fragmented commissioning structures and undermined the NHS's ability to pull together in a coordinated manner towards shared goals.[28] The establishment of NHS England as an arm's length body to the then Department of Health pre-occupied national leadership, and for the early years of the reforms, the mammoth task of establishing the new structures, ensuring co-terminosity, and new accountability mechanisms took precedence over driving progress towards in improvement in clinical outcomes.
2. Respect and autonomy for public service professionals	**The Lansley Reforms put liberation of clinicians at their heart: the central premise was a scaling of the GP's role as 'gatekeeper' to NHS services, with responsibility for an estimated 60% of the NHS budget. The reality, however, fell short of widespread empowerment of clinicians across the NHS.** Moreover, the reforms were introduced with little to no consultation with the medical profession, and enthusiasm amongst GPs for their newfound responsibilities varied significantly, with many citing concerns about workload, distraction from clinical practice and conflicts of interest. Likewise, early criticisms of the proposals pointed to the absence of secondary care and mutli-disciplinary clinical input into CCGs, with just one nominated position on the CCG Board for a consultant doctor. In this way, the reality of clinical commissioning in practice fell to the minority of enthusiastic GP commissioners, and was not experienced as universally empowering for clinicians in the NHS.

27 Checkland, K., Coleman, A., McDermott, I., Segar, J., Miller, R., Petsoulas, C., Wallace, A., Harrison, S., & Peckham, S. (2013). *Primary care-led commissioning: Applying lessons from the past to the early development of clinical commissioning groups in England.* British Journal of General Practice, 63(614), e611–e619. https://doi.org/10.3399/bjgp13X671597

28 Ham, C., Baird, B., Gregory, S., Jabbal, J., & Alderwick, H. (2015). *The NHS under the coalition government: Part one – NHS reform.* The King's Fund.

3. Devolution and alignment	**The Lansley Reforms were the most radical devolution of decision-making in the NHS. Yet the lack of structure and central direction in the original reforms – intended to 'liberate' – ultimately had the converse effect. The years following reforms saw multiple revisions of structures and responsibilities, each introducing greater standardisation.** Lansley's vision of clinician-led and locally determined structures became ever more standardised as attempts were made to simplify the system, such as requirements for co-terminosity with local authority boundaries, or the introduction of Sustainability and Transformation Partnerships (STPs) (2016) in recognition of the need for more regional join up of commissioning. STPs became 42 Integrated Care Systems and then Integrated Care Boards (2022), and at each stage responsibilities for population health and ways of working, including voluntary and community sector involvement, became increasingly standardised.
SERVICES: A NEW RELATIONSHIP BETWEEN DIFFERENT PLACE-BASED PUBLIC SERVICES	
4. Service integration	**The Lansley Reform enshrined competition and choice in the NHS over integration, drawing harsh criticism that measures such as expanding the role of Monitor to guard against 'anti-competitive behaviour' between providers would be the death knell for integration of services.** The reforms sought to drive quality improvement through two routes: the premise that competitive tendering ('competition-for-the-market') would drive innovation, and patient choice of provider ('competition-in-the-market') would favour higher quality providers and thus encourage 'survival of the fittest'. Measures included encouraging greater plurality of provision of NHS services (to include greater numbers of private and VSCE providers),[29] allowing commissioners to award contracts based on quality alone, rather than prioritising NHS providers, and through increasing requirements around patient choice.[30] Taken together the reforms were roundly criticised for effectively destabilising NHS providers, leading to short termism in contracting due to the risks of breaching procurement law, and making it almost impossible for providers to collaborate, pool budgets or integrate services. Within two years of the legislation passing through parliament, national NHS policy was rowing back from choice and competition, making it easier for providers to integrate.[31]

29 Ham, C., Baird, B., Gregory, S., & Jabbal, J. (2015). *The NHS under the coalition government: Part one – NHS reform*. The King's Fund. https://www.kingsfund.org.uk/insight-and-analysis/reports/nhs-under-coalition-government-reform

30 Monitor. (2013, December 19). *Procurement, patient choice and competition regulations: Guidance*. https://www.gov.uk/government/publications/procurement-patient-choice-and-competition-regulations-guidance

31 NHS England. (2014). *Five year forward view*. https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

5. Peer-to-peer learning	**Although not an explicit aim of the reforms, the intense structural change following the introduction of the Lansley Reforms, coupled with the paucity of strong national policy guidance on implementation, meant that clinicians and professionals organically used existing and new learning networks to share learning and insights.** The Lansley reforms threw NHS structures and processes into a period of radical overhaul. In line with the 'liberated' aims of the reforms, and also in large part due to the pace and scale of the changes required, national guidance was often high level or inconsistent. In the face of this uncertainty, and as clinicians and managers across the system grappled with new responsibilities and lines of accountability, professionals mobilised across existing and new networks to share insights and learning. Existing bodies such as the British Medical Association, Local Medical Committees and the NHS Confederation provided advice and guidance, and new organisations such as 'NHS Clinical Commissioners'[32] emerged.
6. Collaboration between different providers	See Principle 4: Service integration
7. Join-up public services with wider social and economic policy	**The establishment of Health and Wellbeing Boards was a welcome step towards encouraging a holistic and strategic approach to tackling social and health outcomes, yet the Boards lacked statutory clout and varied in impactfulness.** The Lansley Reforms established 'Health and Wellbeing Boards' to be hosted by every local authority. The Board brought together representatives of the NHS, local authorities, local VCSE and other services and were required to produce 'Joint Strategic Needs Assessments' and 'Joint Health and Wellbeing Strategies' for their area. Where Health and Wellbeing Boards were successful, they became a valuable forum for local stakeholders to connect, develop shared goals and share insights. However, their powers were only advisory, and CCGs and local authorities were only obliged to have regard for the JSNA and the JHWS in their decision-making.
CITIZENS: A NEW RELATIONSHIP BETWEEN CITIZENS AND PUBLIC SERVICE PROFESSIONALS	
8. Professionals are freed to experiment in line with local variation and citizen need	See Principle 3: Devolution and alignment

32 NHS Confederation. (n.d.). *NHS Clinical Commissioners*. https://www.nhsconfed.org/networks-countries/nhs-clinical-commissioners

9. Strengths-based approach	The Lansley Reforms were grounded in 'no decision about me, without me', the notion that patients should be empowered through greater access to their data and through a shared decision-making approach in their care.[33] Yet, like the NHS Plan of the early 2000s, this version of 'patient centredness' guided individual patient interactions with clinicians, rather than as a guiding principle for service design.
10. Services designed with citizens, through co-production and participation	The Health and Social Care Act required CCGs to 'involve patients and the public' in their planning and commissioning, and appoint lay members to their governing Boards. Yet these requirements lacked depth or detail, and whilst the majority of CCGs established 'Patient Participation Groups', they fell far short of the co-design processes in which citizens are equal partners in service design. The main emphasis of patient empowerment in the Lansley Reforms as in new requirements for transparency and greater accountability mechanisms for patients to hold providers to account. Patient choice was also very much conceived as a lever to allow patients to shape the provider environment (effectively 'voting with their feet'). In this way, the reforms aimed to reshape the health service to be 'patient centric'.

The Liberated verdict

The Lansley Reforms explicitly echoed the language of liberation, including the very name of the White Paper, *Equity and Excellence: Liberating the NHS*. Frontline empowerment, devolution to clinicians, and reduced central control were framed as central to the Reforms' theory of change; hence, judged on stated ambition, the reforms align closely with the liberated principles.

In implementation, bureaucracy held back significant progress towards achieving the reforms apparent aims. CCGs inherited the rhetoric of clinical leadership and the operational reality of contract management and immense bureaucracy, with procurement risk and contractual complexity making integration extremely difficult to design. This unsuccessful devolution created fragmentation, and ultimately led to regional commissioning being re-established through STPs, then later through ICSs.

Although not an explicit goal, the pace of structural change and the thinness of national guidance prompted clinicians and managers to mobilise through existing networks to share insights and learning – to an extent that peer-to-peer learning genuinely expanded.

Most significantly, the reform enshrined choice and competition as the primary mechanism for quality improvement, with expanded provider plurality, procurement-based commissioning, and a strengthened role for Monitor in policing anti-competitive behaviour. Relational outcomes require accountability architectures, funding mechanisms, procurement ecosystems, and governance arrangements that are themselves designed to support relational ways of working. As these underlying structures were left untouched (or were restructured around competition) the Lansley reforms broadly failed to deliver against the liberated principles.

33 Department of Health. (2010). *Equity and excellence: Liberating the NHS*. The Stationery Office. https://www.gov.uk/government/publications/liberating-the-nhs-white-paper

SECTION 4
THE NHS 10 YEAR PLAN "FIT FOR THE FUTURE" (2025)

"The plan breaks with the fiction that you can run a health service, one and a half million staff who deliver 600 million patient interactions every single day, from an office building in Whitehall.

Power and resources should flow to local providers, frontline staff, and ultimately be placed in the hands of patients."

– Secretary of State for Health and Social Care Wes Streeting

Overview and rationale

The 10 Year Health Plan (July 2025) was launched with the warning from the government that it was 'reform or die' for the NHS. The Starmer government had been elected a year before on both the promise of tackling waiting lists and GP access, and also a grand commitment to mission driven government. There was a daunting task ahead then: dramatically improve day to day experience of services for patients, whilst also addressing long term goals such as shifting healthy life expectancy embodied in the Health Mission.

The development of the plan certainly embodied liberated principles: a large-scale engagement exercise with 250,000 patients, the public and NHS professionals (both frontline staff and NHS leadership), and deliberative events to explore the trade-offs and decisions ahead.

The reforms that resulted from this engagement – the 10 Year Health Plan – reflected the tension between the challenges of the here and now, whilst trying to re-orient the health service towards promoting future health. The reforms formally launched three 'big shifts' (though these were referenced in ministerial speeches and the Darzi review, before being formally announced): hospital to community, analogue to digital, and sickness to prevention. The long-term aims were mission-like in nature, and the reforms went some way to identify the tangible shifts in structures, funding and accountability to deliver.

The reforms also sought to facilitate integration (e.g. through the development of neighbourhood health) and centre patient involvement in care decisions through expansion of Personal Health Budgets, Personalised Care Plans and the Single Patient Record. Yet despite a commitment for 'power and resources to flow to frontline services', new accountability mechanisms and central intervention for poorly performing providers threaten to undermine

this shift, instead retrenching organisational sovereignty and competition at precisely the time collaboration is required to deliver the necessary reform, particularly in arenas such as neighbourhood health.

TABLE 6
SCORECARD OVERVIEW: THE NHS 10 YEAR PLAN (2025)

	LIBERATED PUBLIC SERVICES SCORE CARD: The NHS 10 Year Plan (2025)	AMBITION	REALITY
THE CENTRE: A NEW RELATIONSHIP BETWEEN CENTRAL GOVERNMENT AND THE DELIVERY OF PUBLIC SERVICES.	1. Mission-driven public services		
	2. Respect and autonomy for public service professionals		
	3. Devolution and alignment		
SERVICES: A NEW RELATIONSHIP BETWEEN DIFFERENT PLACE-BASED PUBLIC SERVICES	4. Service integration		
	5. Peer-to-peer learning		
	6. Collaboration between different providers		
	7. Join-up public services with wider social and economic policy		
CITIZENS: A NEW RELATIONSHIP BETWEEN CITIZENS AND PUBLIC SERVICE PROFESSIONALS	8. Professionals are freed to experiment in line with local variation and citizen need		
	9. Strengths-based approach		
	10. Services designed with citizens, through co-production and participation		

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TABLE 7
IN DEPTH ANALYSIS: THE NHS 10 YEAR PLAN (2025)

THE CENTRE: A NEW RELATIONSHIP BETWEEN CENTRAL GOVERNMENT AND THE DELIVERY OF PUBLIC SERVICES	
1. Mission-driven public services	**The 10 Year Health Plan is the most 'mission-esque' of the reforms (and has remained even as the mission framing has been dropped), establishing three clear goals.** The 10 Year Health Plan outlined three 'North Star' type goals: shifting care from hospital to community; analogue to digital; and from sickness to prevention. These overarching goals provide a Mission-type framing for the Plan: they are long-term, require cross-disciplinary collaboration and are ambitious but measurable.[34] Unlike the NHS Plan (2000), which focussed on activity and targets, or the Lansley Reforms, guided by high level but ill defined ambitions to 'liberate', these identify tangible shifts for the health service. The 10 Year Health Plan also speaks to cross-sector mobilisation required to achieve these goals – a defining feature of mission-driven government. Commitments around prevention, which remains the weakest elements of the the plan, in particular reference the 'huge cross-societal energy'[35] required, and identify commitments that span education, employment and manufacturing policy.
2. Respect and autonomy for public service professionals	**The 10 Year Health Plan includes commitments to improve training and personal development for NHS staff, alongside measures to reduce bureaucracy, but falls short of the emphasis on 'liberation' of NHS professionals embedded throughout the Lansley reforms.** Throughout the plan there are mentions of measures to support NHS staff to innovate, for example through digital enablement, greater access to data; AI tools and scaling back of central targets to free up more time for clinical care. But these measures lack detail and are focussed on giving staff autonomy to perform their current roles, rather than devolving decision making powers.
3. Devolution and alignment	**The 10 Year Health Plan commits to 'high autonomy' as the norm for local areas, but limits it to high-performing providers, meaning poorly performing areas miss out on the benefits of innovation and place-based autonomy.** Ambitions to 'push power out to providers, people and places' are backed up by commitments to formalise existing regional commissioning structures such as Integrated Care Boards and scale back the size and complexity of the 'centre' by collapsing NHS England back into the DHSC (thus reversing the Lansley Reforms).

34 Glover, B., O'Brien, A., & Phillips, A. (2025, February). *Mobilisation nation: Why the government's missions need enabling reforms.* Demos. https://demos.co.uk/wp-content/uploads/2025/02/Mobilisation-Nation_2025_Feb.ac_.pdf
35 Department of Health and Social Care. (2025, July). *Fit for the future: 10 year health plan for England.* The Stationery Office. https://assets.publishing.service.gov.uk/media/6888a0b1a11f859994409147/fit-for-the-future-10-year-health-plan-for-england.pdf

	The requirement for ICBs to be co-terminous with mayoral strategic authorities (a move driven by MHCLG not DHSC) is a welcome step towards enabling greater local collaboration, as are the 'Health Commissioners' pilots in Greater Manchester and South Yorkshire – a mayorally appointed Chair of ICBs who is accountable to both the mayor and the Secretary of State for Health and Social Care. The 10 Year Health Plan outlines a vision of 'earned autonomy' for providers, with higher performers rewarded with freedoms to innovate, and – echoing the NHS Plan (2000) stricter failure regimes for poorer performing providers. By restricting access to the ability to innovate to areas that are already high performing, the proposals risk entrenching outdated models of service provision and public service management to areas that are already less successful. Similarly, the Plan's ambitions for how AI and data could unlock local innovation and inform service design are welcome, but lack detail. Whether these ambitions are realised will be heavily dependent on the implementation of the new operating model, accountability regimes and commitments to properly resource neighbourhood health.
SERVICES: A NEW RELATIONSHIP BETWEEN DIFFERENT PLACE-BASED PUBLIC SERVICES	
4. Service integration	**Neighborhood Health – integrated provision of care in community settings – embeds integrated, community services in every area in England.** The establishment of 'neighbourhood health services', and associated shifts in funding, signals a significant shift towards integration, the development of multi-disciplinary teams and care closer to home. The introduction of new single and multi- 'neighbourhood provider' contracts could in theory enable primary and secondary care organisations and others to work at greater scale to integrate services. The vision is for the neighbourhood health service to be fully digitally enabled, providing patients with easy access to a range of services, self-referral options and AI enabled advice.
5. Peer-to-peer learning	**Peer-to-peer learning is not a key focus of the 10 Year Health Plan.** However, the establishment of the National Neighbourhood Health Implementation Programme is a welcome example of how to spread learning and develop supportive communities of practice across the health service.
6. Collaboration between different providers	**The 'Neighbourhood Health Service' envisaged by the 10 Year Health Plan is founded in collaboration between providers, and the reforms go further: envisaging a role for local authorities, industry, employers and investors in proposals around preventative health.**

	Neighbourhood Health offers a model of joined-up care built on collaboration between primary and community care, facilitating involvement of secondary care, community pharmacy and the third sector. In contrast to previous reforms, these proposals include, over time, the requisite shift of funding from secondary care to Neighbourhood Health services. In some ways more excitingly, the 10 Year Health Plan's reference of 'cross-societal energy' signals appetite for a more expansive vision of collaboration – though it should be noted that key stakeholders such as the LGA were not happy with the level of engagement carried out. The Plan references the role of industry in supporting innovation, employers in promoting health, investors harnessing capital towards improving health and local authorities working on the links between health and local growth. All these actors have a crucial role in embedding prevention and improving health outcomes, yet the policy and practice levers to drive progress sit across government (e.g. the work of Department for Work and Pensions). For a government elected on the promise of mission-driven government, the 10 Year Health Plan is perhaps the government's most 'mission-esque' set of reforms, yet the delivery architecture (cross-government objectives and accountability) required for a truly mission-driven approach is lacking.
7. Join-up public services with wider social and economic policy	**The 10 Year Health Plan articulates the most holistic conception of prevention of the three reforms, yet remains light on new concrete proposals. Yet many of the proposals re-iterate existing government policy (e.g. the Tobacco and Vapes Bill) and fall short of the 'health in all policies' approach needed to reshape broader government policy making towards health.** The 10 Year Health Plan includes clear recognition of the social, economic and commercial drivers of health, and the devastating impact of rising health inequality not just on individual outcomes, but on growth and societal resilience. Proposals relating to prevention include measures such as Health and Growth Accelerator models, junk food advertising restrictions, and extension of Free School Meal provision. The plan commits to targeting activity in the areas where healthy life expectancy is lowest and health outcomes are the worst. Yet the 10 Year Health Plan remains, ultimately, a Health (Service) Plan. The reforms harvest promising government initiatives towards their preventative aims, but fall far short of the sort of radical reforms needed to embed health across government. These would include mission-type approaches such as shared accountability across Department of Work and Pensions, Department for Business and Trade and the Department for Health and Social Care for the role of employers in promoting health.

CITIZENS: A NEW RELATIONSHIP BETWEEN CITIZENS AND PUBLIC SERVICE PROFESSIONALS	
8. Professionals are freed to experiment in line with local variation and citizen need	See Principle 3: Devolution and alignment
9. Strengths-based approach	**The 10 Year Health Plan contains welcome commitments to extending provision of personalised care plans, Personal Health Budgets and, most importantly, the Single Patient Record, all of which, when used well, have been shown to empower patients in decisions about their own care.** The 10 Year Health Plan includes commitments to increase the proportion of people with complex needs with a personalised care plan from 20% to 95%, and extend Personal Health Budgets from 180,000 to 1m by 2030. In addition to this, improvements to the NHS app and the ambition for the app to act as a single front door to community, primary and secondary care services, as well as a source of digitally enabled advice, are intended to empower patients in accessing services and shaping their own care.
10. Services designed with citizens, through co-production and participation	**Large scale and participatory engagement on the reforms signalled a welcome new approach to government consultation, but the 10 Year Health Plan remains light on on embedding citizen involvement in ongoing decisions about service design.** The patient and public consultation for the government's 10 Year Health Plan was run as a broad "national conversation," inviting input from patients, NHS staff, and organisations, via a dedicated website Change.NHS.[36] People could contribute through online surveys, public events, and formal submissions, aiming to capture lived experience and priorities alongside expert views. Over 250,000 patients, professionals and organisations submitted their views, with 730 patients taking part in deliberative events, making the consultation one of the largest and most participatory government engagement exercises. However, the reforms themselves are light on proposals to embed deliberation or citizen-design in ongoing decision-making in the health service.

36 Department of Health and Social Care. (2025, December 17). *Engagement insight report: 10 year health plan for England.* https://www.gov.uk/government/publications/engainggement-insight-report-10-year-health-plan-for-england

The Liberated verdict

The 10 Year Health Plan demonstrates the closest alignment between the stated ambition of reform and the principles of liberated public services. The three shifts have a mission framing, ambitiously aiming to move care from hospitals to communities, from analogue to digital, and from sickness to prevention. The development process was genuinely participatory at scale. Neighbourhood Health, Personalised Care Plans and Personal Health Budgets all reflect welcome movement towards a more relational model of care, and the Plan's recognition of social, economic, and commercial drivers of health represents a holistic conception of prevention.

There are also areas of divergence between this ambition and the architecture being built to deliver it. Ambitions to push power out to providers sit alongside new accountability mechanisms and central intervention regimes for poorly performing providers, which threaten to undermine commitments to local autonomy. Earned autonomy grants the freedom to innovate to providers already performing well, leaving lower-performing areas without access to the same flexibility and risking the entrenchment of outdated models where reform is most needed. Public participation was embedded in the design of the Plan, but is largely absent from the governance of the services. The mission framing extends to cross-societal mobilisation on prevention, but the cross-government accountability that mission-driven reform requires is dispersed across departments where the Plan has no formal purchase

The ambition aligns with the liberated principles to a greater extent than the reforms that preceded it. Whether implementation follows the same trajectory will depend on whether accountability mechanisms, funding structures, and governance relationships between the centre and the frontline are aligned with the relational behaviours the reform sets out to support, or whether the underlying architecture continues to pull in the opposite direction.

CONCLUSION AND RECOMMENDATIONS

The table below contains the 'scorecard' for each set of reforms, demonstrating a shift in ambition towards liberated principles across the three NHS restructures (as evidenced by the shift from red to green). However, the scorecard also demonstrates that each of the two previous reform agendas fell short of ambitions in implementation. The analysis of each reforming agenda is explored in more detail below.

TABLE 8

SCORECARD OVERVIEW: THE NHS PLAN, EQUITY AND EXCELLENCE, AND THE NHS 10 YEAR PLAN

		NHS Plan (2000)		Lansley Reforms (2012)		10 Year Health Plan (2025)	
Liberated Public Services Score Card:		Ambition	Reality	Ambition	Reality	Ambition	Reality
CENTRE	1. Mission-driven public services						
	2. Respect and autonomy for public service professionals						
	3. Devolution and alignment						
SERVICES	4. Service integration						
	5. Peer-to-peer learning						
	6. Collaboration between different providers						

	7. Join-up public services with wider social and economic policy						
CITIZENS	8. Professionals are freed to experiment in line with local variation and citizen need						
	9. Strengths-based approach						
	10. Services designed with citizens, through co-production and participation						

One health service, three very different sets of reforms, driven by three governments with very different political contexts. Despite this, our analysis identifies four themes that offer particularly rich insight for the current reforms, with associated recommendations for the current 10 Year Health Plan.

1. **The Centre**: Mission framing, without mission machinery
2. **Services**: Accountability eats culture for breakfast
3. **Citizens**: Embedding participation
4. **Implementation**: The importance of prioritisation

The Centre: Mission framing, without mission machinery

Of all the reforms, the NHS Plan – with its focus on structures, tangible targets, record investment and command and control – most closely embodied a technological mission. The Plan was hugely successful by many measures, including in achieving record patient satisfaction, but entrenched a rigid target culture, perverse incentives and prized consistency over local innovation: an example in how resource, discrete goals and a technocratic approach – all signature characteristics of technological missions – can only go so far in the context of the health service. What's more, neither the NHS Plan, nor the Lansley Reforms, which were fundamentally un-missionlike in lacking tangible clear goals, spoke in any substantive way to the socioeconomic context to health and health service reform.

This is where the 10 Year Health Plan shifts the dial. The three shifts – from hospital to community; analogue to digital; and sickness to prevention – outline three strategic north stars for the reforms, creating a fundamentally mission-like framing. Yet the delivery thus far of the reforms has lacked a mission infrastructure, and in practice the result is financial recovery and organisational restructure have, in the vacuum, taken priority over a more strategic and outcomes based approach

The three shifts go further than the other reforms to speak to the socioeconomic factors at play (e.g. the 'cross-societal mobilisation' required on prevention). But calls for cross-government action on health are not accompanied with the required cross-government ownership, collaboration or accountability. The 10 Year Plan relies on policy being driven forward elsewhere in government – Free School Meals, for example – for delivery of action on the socio-economic drivers of ill health, and these policies largely existed prior to the announcement of the reforms, and belong to separate policy agendas. These reforms remain – as previous attempts were – an agenda for the health service, rather than signalling a joined-up, cross-government mission like approach.

It would be easy to recommend the establishment of cross-departmental working groups to address this. However, in the context of the reforms as framed, any efforts at 'cross-government' working on the 10 Year Plan will be shallow and tokenistic: where the 10 Year Health Plan references policy outside the health service, there is no sense of shared agenda or shared accountability for outcomes.

What is needed is a sense of shared mission across the entirety of the government's public service reform agenda. These health reforms are being implemented in parallel with other major reform agendas: devolution and the establishment of Mayoral Strategic Authorities; the establishment of a National Police Service and major restructuring of local policing; the Best Start in Life strategy and establishment of Family Hubs; Pride in Place. For example, the Neighbourhood Health Policy Framework itself lists 16 other government policies or programmes that Health and Wellbeing Boards, responsible for developing the mandated local Neighbourhood Health Strategy, 'may wish to consider'. Yet there is no consistent consideration of how these various structural reforms interact with each other, or spotting the opportunities for join-up in respective shifts to more preventative approaches.

The government emphasises cross-agency working and 'joined-up services' across all these agendas, yet there is a striking lack of join-up in central government.

> ***Recommendation**: A Cabinet Office 'Public Service Reform Board', chaired by the Chief Secretary to the Prime Minister, to be established to coordinate across overlapping public service reform agendas, identify potential duplication, areas for collaboration and cross-pollinate learning.*

Services: Accountability eats culture for breakfast

Each set of reforms has grappled hard with notions of 'autonomy', 'devolution' and 'accountability' with wildly varying impacts. The NHS Plan was unashamed in its reassertion of central dominance to ensure consistency and quality of services. Regional structures – PCTs and SHAs – despite being largely successful local commissioning bodies, were most often required to act on central edict. Likewise, rigid performance management of providers and central involvement where performance was poor disincentivised local innovation and embedded risk aversion. On the other hand, Lansley's full throttle commitment to liberation came at the expense of strategic direction, service performance and launched the NHS into a decade of bureaucratic and structural chaos.

The 10 Year Plan presents a more nuanced, and, some might argue, confused picture. On the one hand, refocusing ICBs on their strategic commissioning role and rewarding high performing providers with more freedom to innovate – alongside Neighbourhood Health –

signals commitment to local determination. And the rationale behind folding NHS England into DHSC was to 'streamline' the centre. Yet, 14 years on from the Lansley Reforms, this 'streamlining' means that in practice DHSC is absorbing a range of statutory duties previously held by numerous arm's length bodies, including NHS England, Public Health England, Medical Education England and Healthwatch. The result is a centre that is vastly increased in size, with little indication of inclination to 'push power out', in the words of the Secretary of State.

At the same time, accountability is swinging back to the 2000s-esque love of league tables, right down to more Secretary of State influence over performance management of senior NHS leaders. Whilst the latest reforms embrace the language of innovation far more than the 2000 NHS Plan, 'earned autonomy' risks limiting the benefits of innovation to providers that are already highly performing, rather than supporting those who need it most to try new approaches.

> ***Recommendation**: Involvement of the centre in poorly performing providers should avoid simply implementing 'failure regimes', but use the intervention to implement a 'supported innovation' model.*
>
> *The focus would not simply be improving performance to meet an agreed baseline, but to embed the skills and capacity for these providers and commissioners to collaborate, innovate and learn from highly performing areas who are already benefiting from 'earned autonomy'. In this way, the benefits of innovation are not just limited to the most highly performing providers.*

Citizens: a shift towards liberated principles

All three sets of reforms commit variously to 'patient centredness', yet there has been a marked shift in how this concept is interpreted, from transactional and consumer-centric conceptions in the earlier reforms to a model that begins to treat patients as co-partners in their own care in the 10 Year Plan. The 'patient as customer' of the early 2000s sought to empower patients through improving customer experience of the health service: improved telephony and booking systems meant less time and effort to access health services, with the focus on patient satisfaction. The Lansley Reforms, conversely, viewed choice and competition as the ultimate patient empowerment. Patients would 'vote with their feet', exercising control over their own care, and, through market forces, shape service commissioning and delivery in their area.

Yet both models embody inherent power dynamics, in which patient interaction with services is transactional. Customer experience can be smooth, choice can be extensive, but neither require patients to be treated as equal partners and experts in their own care. In this way, the 10 Year Plan is a welcome shift towards liberated principles. The expansion of Personalised Care Plans and Personalised Health Budgets offer millions of people with the most complex needs the opportunity to shape decisions about their own care.

And whilst public engagement in the development of the Plan was by far the most extensive, the resulting reforms speak very little to embedding a culture of co-design with the public and patients into the new structures. There are promising examples of local areas involving citizens in the development of neighbourhood health,[37] but statutory duties remain light, and focussed around collaboration between the Health and Wellbeing Board (involving democratically elected councillors and local community organisations) and ICBs in the development of Neighbourhood Health Plans as a means to increase community involvement.

37 https://neighbourhood-health.co.uk/case-studies

***Recommendation**: The upcoming Health Bill 2026 should mandate citizens panels 'Neighbourhood Boards' to be established as part of every ICB, with clear roles and responsibilities in terms of ICB decision-making.*

Learning from Neighbourhood Boards developed as part of the Pride in Place Programme can inform the successful establishment and development of these boards.

Implementation

Learning from past reforms demonstrates that asking the system to reorganise whilst running is unsustainable. The Lansley Reforms mired the system in years of bureaucratic restructuring, with detrimental impact on quality of care. Likewise, the NHS Plan illustrated how high priority political targets (e.g. reductions in waiting times) provide strong incentive for action – with highly successful results – but can crowd out more innovative, local-driven quality improvement.

The health service is currently being asked to implement changes to both provider and commissioning structures, whilst also deliver on the Secretary of State's highly visible and high stakes commitments on waiting times and access. This is a tall order for a service beleaguered by interminable financial pressures, an impossible mismatch between capacity and demand, and staffed with a fatigued workforce. If the centre is to stay true to its commitment to 'push power out' and respect local autonomy, the first step needs to be in providing clarity about priorities. The delivery of any complex and mutli-faceted change programme, or indeed, government mission, relies upon clear signalling of expectations.

***Recommendation**: Building on the Medium Term Planning Framework (2026/27-2028/29),[38] DHSC should require and support ICBs to undertake an explicit prioritisation exercise to identify a small number of locally determined strategic priorities.*

These priorities should be accompanied by permissive national guidance to enable the sequencing and phasing of all other activity within the Medium Term Planning Framework, thereby ensuring realism in delivery and coherence between national priorities and local system capacity.

Conclusion

This paper has explored 25 years of NHS reform, examining a persistent tension at the heart of public service transformation: the gap between reform ambition and the system conditions required to deliver it. Across the NHS Plan (2000), the Lansley Reforms (2012), and the 10 Year Health Plan (2025), there is some striking continuity of intent – improving outcomes, strengthening accountability, and reshaping services around patients and citizens. Yet each reform has interpreted these principles and translated these ambitions into practice in different and often competing ways, reflecting shifting political ideologies and theories of governance.

38 chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.england.nhs.uk/wp-content/uploads/2025/10/medium-term-planning-framework-delivering-change-together-2026-27-to-2028-29.pdf

We have viewed these reforms through the lens of Demos's 10 Principles for Liberated Public Services, a framework that we are exploring the use of as a diagnostic tool for public service reform agendas. The analysis reveals not a linear progression towards a more relational system, but a cyclical pattern in which advances in one domain are repeatedly offset by unintended consequences elsewhere. Strong central control has delivered measurable gains in performance, but at the cost of innovation and local agency. Decentralisation has increased autonomy in principle, but produced fragmentation in practice. Efforts to embed integration, prevention, and citizen participation have repeatedly been undermined by misaligned incentives, siloed funding flows and risk aversion.

The central lesson is that reform failure is rarely the result of weak ambition. It stems instead from a failure to align the underlying operating system of public services – accountability structures, funding flows, culture – with relational models. The NHS has repeatedly been asked to behave in more integrated, preventative and citizen-centred ways while being governed through systems designed for hierarchy, compliance and control.

We make practical recommendations to support alignment of governance, citizen involvement and the relationship between the centre and local actors to deliver against the relational ambitions of the 10 Year Health Plan.

Yet our analysis also reveals a broader and more fundamental point: health reform cannot be understood in isolation. It is one strand of a wider public service reform agenda spanning devolution, policing, early years, skills, and place-based economic renewal. These agendas share strikingly similar language and intent – prevention, integration, localism – yet remain largely developed and implemented in parallel.

This fragmentation at the heart of government represents both a risk and a missed opportunity. The risk is that overlapping reforms compete for the same constrained implementation capacity, duplicate governance structures, and send inconsistent signals to local systems. The opportunity, by contrast, is significant: there is now a genuine convergence of reform intent across government, but it is not yet matched by shared ownership or joined-up delivery architecture. In practice, the same places, partnerships and professionals are being asked to deliver multiple, partially aligned transformations without a single integrated narrative.

The challenge then, is no longer only how to deliver better health reform, but how to situate health reform within a coherent cross-government settlement for public service reform. Without this, even well-designed health policies risk mis-alignment with adjacent reforms. This requires not only coordination, but genuine joint ownership of outcomes across central government departments, and at local level, with aligned accountability, pooled learning, and consistent signals from the centre.

Ultimately, the history of NHS reform demonstrates that where successive reforms have driven progress in one area – such as performance targets or local empowerment – only to neglect or unintentionally derail another part of the system, the system as a whole is vulnerable to dysfunction and will be stuck in seemingly endless reform cycles to recalibrate. What matters is coherence, between ambition and delivery, yes, but also between the reforming objectives and the underlying pre-conditions necessary for reform: accountability, culture, funding and narrative.

Crucially, the scale of reform required across the public sector means it is no longer enough to aspire for coherence and join-up *within* a public service (such as health) as a standalone delivery challenge. The centre has a responsibility to provide a clear overarching steer across the full reform agenda—aligning evolving structures, roles and responsibilities, reducing competing

demands, and enabling systemic sharing of learning.

At the time of writing, Andy Burnham is expected to become the next prime minister, having pledged the most ambitious devolution agenda in a generation. This analysis provides three key insights to inform how he implements his agenda across public services.

First, devolution embeds reform; it does not deliver it automatically. The history of NHS reform provides a lesson on the limitations of reforms where the centre devolves in name only. A genuinely transformative agenda requires moving power out of Whitehall. But this cannot be just a transplanting of a command and control approach from Whitehall to combined authorities. Agency must be given to the frontline, to citizens and to the communities they inhabit.

Second, delivering on that ambition means confronting the institutional machinery itself. This report shows that the 10 Year Plan, though framed as central to a government mission, has not been supported by reforms to the underlying infrastructure. In its absence, restructures and financial recovery have crowded out strategic reform, and accountability remains fragmented across too many siloed institutions. Standing up specific units such as a Public Service Reform Board in the Cabinet Office would help ensure the wider apparatus of the state enables the reforming agenda rather than stifling it.

Third, the framework set out here can be a blueprint for evaluating and assuring the full spectrum of public service reform being realised across the state. An incoming administration will be stepping into a vastly complex reforming agenda. They will need to quickly grapple with what is working and what isn't.

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