THE GOVERNMENT'S 10 YEAR HEALTH PLAN: A HEADLINE REVIEW

With the NHS celebrating its 77th birthday on 5th July 2025, the UK Government offered an early gift in the form of the ***10 Year Health Plan for England***. The plan comes at a critical juncture, with the NHS under severe strain. The UK government's strapline – that the NHS is 'broken' – has resonated with the public. With previous strategic healthcare plans seemingly unable to steady the ship, can this latest plan succeed?

At ***CEPA***, we have reviewed the plan analytically, from an ***economic and policy perspective***. Below is our perspective of the plan's top three 'flagship' reforms and three critical underpinning assumptions. For each, we discuss the economic and policy rationale, risks, measures of success, and an overall assessment. Given the comprehensive nature of the plan, this analysis is selective. To note: Whilst the government has identified 'prevention' as one of its 'three shifts' (alongside community care and digitisation), our analysis considers that *greater accountability and stronger incentives* are a more prominent reform theme across the plan, so our view of the plan's 'flagship' reforms is slightly different to the government's 'three shifts'.

Flagship reforms that the plan is counting on	
1	Local **'neighbourhood' health teams** can quickly deliver efficient care that patients value.
2	**Digitisation and innovation** can turbocharge NHS productivity and modernise the NHS.
3	Stronger accountability and **higher expectations** will sharpen incentives and improve performance.

Critical assumptions for success	
4	**Prevention** on ill health can be improved through a range of cross-government initiatives.
5	The NHS can deliver annual **productivity** gains of 2% over the next three years.
6	Constraints: The NHS can recover without short-term social care reforms, or much extra capital and/or workforce.

(1) 'NEIGHBOURHOOD' HEALTH TEAMS

Economic and policy rationale. Currently, insufficient primary and community care capacity has resulted in higher volumes of hospital-based A&E attendances and outpatient appointments. Community care – in the right clinical circumstances – is typically considered cost effective, can improve patient access, and can deliver value for money by freeing up hospital capacity for more specialist care. Evaluations of Integrated Neighbourhood Teams (e.g. in Derby) and virtual wards (e.g. in South East England) have largely been positive, facilitating fewer hospital stays and 'avoided' activity. The focus on integration supports collaborative working across the NHS and other government services, which can help to support a more holistic approach to health, by addressing the wider determinants of health.

Qualifications and risks. This model is not an entirely new concept, e.g. it has similarities to polyclinics of the 2000s. In some cases, it will represent an iteration (not a radical overhaul) of health services, as some 'new' centres will involve co-location of services within existing NHS facilities. It will rely on accurate triage to avoid 'false economies', e.g. where patients are seen first in the community and then referred to hospital as well. There may be short-term double-running costs, both in terms of funding and leadership bandwidth, due to the need for service reorganisation and some capital planning.

Measures of success: Activity and funding should shift (proportionately) to community settings. Cost savings should more than offset any transitional double-running costs. Patient outcomes and satisfaction (e.g. for virtual care) will require monitoring for improvement, including across different age cohorts.

Overall assessment Hospitals currently undertake activity which could be done locally and/or virtually. As such, this model represents the right direction of travel. Delivery should focus on providing certainty around organisational responsibilities, minimising costs of reorganisation and underpinning this activity shift through revised funding flows.

(2) DIGITISATION AND TECHNOLOGICAL INNOVATION

Economic and policy rationale. Lord Darzi's 2024 investigation found that the NHS is '15 years behind' the private sector in implementing some relatively basic technologies, e.g. the NHS lacks online booking platforms and standardised data that is transferrable across healthcare organisations, and still uses paper records. This risks patient safety, creates inefficiency and constrains 'joined-up' patient care. Technology is creating some policy 'sweet spots': For example, AI-supported automation of patient note-taking for GPs (which is improving rapidly) is a genuine 'win-win' of efficiency and satisfaction for patient and clinician. NHS England believes offers the greatest hope of productivity and quality improvements.
Qualifications and risks. Historically, the NHS has struggled to digitise, and to effectively spread and implement new technology. Even more critically, the NHS still lacks basic IT fundamentals (e.g. availability of computers, time wasted with multiple sign-ons, etc.). Rapid technological change risks inequalities, e.g. due to differential digital literacy, access to technology and personal preferences. The proposal to provide some wearables/devices for free will require analysis around additionality (cost/benefit) and distribution.
Measures of success. Delivery of the NHS app (including the single patient record), to time and budget. Subsequently, high patient downloads and usage when the app is live. High staff satisfaction (e.g. GPs) around ability to reduce administrative tasks, and evidence of productivity gains and cost efficiencies.
Overall assessment ❤️ Modernising the NHS via digitisation and innovation is critical to providing care that is safe, high-quality and efficient. With some NHS processes appearing outdated, prioritising digitisation is close to a 'no brainer'. Implementation is a known challenge (to achieve both local ownership and sufficient national standardisation and/or interoperability). Delivery on the latest technologies should not be at the exclusion of addressing some basic technological deficiencies.

(3) 'HIGHER EXPECTATIONS': STRONGER ACCOUNTABILITY AND SHARPER INCENTIVES

Economic and policy rationale. The NHS is a fully-funded public service, which is free at the point of delivery. This is simultaneously its greatest strength – it is highly equitable – and its greatest weakness – it lacks 'sharper' incentives common to other sectors. Financial deficits and missed operational performance targets occur with regularity, along with sporadic patient safety incidents. In principle, stronger accountability can increase organisational focus and urgency towards the targeted objectives. The plan creates 'sharper' incentives for providers – including structural devolution, organisational autonomy and optionality (including vertical integration), provider tariff reforms, leadership remuneration and greater transparency. For example, the plan states that "*persistent poor-quality care [will] result in the decommissioning or contract termination of services or providers.*" For individuals, the plan discusses the development of some rewards ('carrots' rather than 'sticks') to incentivise healthy choices.
Qualifications and risks. NHS organisations and their staff have a range of motivations, which include reputation and finance, as well as public service. Rewarding performance may have trade-offs, such as undermining collaboration, or exacerbating the performance gap between providers, which can exacerbate healthcare inequalities. Performance can be complex to measure as it depends on changing inputs (e.g. revisions to funding allocations) and there may be lags between performance and patient outcomes. Stronger performance management increases the incentive for gaming by providers.
Measures of success. Improvements in performance against government targets, e.g. A&E attendances seen within four hours. In terms of risks, the NHS should monitor staff satisfaction, the dispersion of trust performance (and impacts on health inequalities), and undertake analysis for evidence of gaming.
Overall assessment 🤔 Provider performance management methodologies tend to be imperfect, with NHS regimes shifting 'back-and-forth' over time (e.g. more scrutiny in the 2000s and early 2010s and greater collaboration more recently). The plan raises several key risks and questions: (1) What regime design will allow the NHS to improve overall performance if poor-quality care is decommissioned? (2) Alongside the 'sticks', how will the government strengthen its support offer to providers, to help to prevent poor-quality care from arising? (3) With accountability largely directed towards providers, how can the NHS improve incentives for individuals to improve their own health?

(4) PREVENTION THROUGH CROSS-GOVERNMENT ACTIONS

Economic and policy rationale. Healthcare's contribution to an individual's health is estimated to be well below 50%, with wider social determinants (such as housing and employment) having significant impacts. The plan includes a range of cross-government measures, including working with supermarkets to reduce obesity, anti-smoking legislation for young people, and employment support. Prevention enables people to stay healthy and happy for longer. With NHS care being 'free at the point of delivery', prevention is a non-market lever to manage demand. Preventative measures are often relatively cost effective.
Qualifications and risks. Prevention may have longer-term impacts (e.g. the effects of smoking on cancer rates) so benefits are challenging to measure. Whist preventative measures may have a high return on investment, that can increase costs in the long term due to higher life expectancy and population aging. Working across government departments generates challenges around accountability, including uncertainty as to the contribution to health from each department's initiatives.
Measures of success. In the longer term, prevention is likely to manifest in lower incidence of disease and illness, including both physical and mental health conditions, with reductions in associated healthcare activity. In the short term, measures of prevention may need to be activity-based or output-based, such as take-up of the 'new health reward scheme', levels of smoking and alcohol consumption, and diet patterns.
Overall assessment 🤞 The plan offers a 'mixed bag' of prevention measures, without pushing as strongly towards prevention as it might have done. This may be due to prevention's relatively long-term payoff (which disincentivises investment), cross-government coordination challenges around delivery, and resourcing constraints across departmental budgets. Nonetheless, further mechanisms could be explored to *go further* on prevention, e.g. by leveraging health data to better explain and communicate personalised risks and benefits arising from lifestyle choices, or by developing AI-supported solutions to joint-working across departmental silos.

(5) PRODUCTIVITY GROWTH TARGET OF 2% PER ANNUM

Economic and policy rationale. The NHS experienced a decline in productivity during Covid-19, from which it has yet to fully recover. Productivity growth at 2% per annum up to 2030 would be sufficient to offset this deficit and 'catch up' to the pre-Covid trajectory. Genuine productivity gains – where more (or better-quality) activity can be delivered for the same inputs – is a best-case economic solution as it enables finite NHS resources to stretch further, supporting quality of care and financial balance. With the NHS consuming almost 40% of government day-to-day funding, it is critical that the NHS achieves value for money, particularly given efficiency targets for government departments at the Spending Review.
Qualifications and risks. Historically, NHS productivity growth has averaged close to 1% per annum. so achieving double this rate for the next three years is a stretching target. If providers seek to achieve productivity growth through cost reductions, this may have trade-offs in terms of quality of care or the quantity of activity delivered, e.g. South East London ICS's plan for 2025/26 is premised on a workforce reduction of almost 4%. Achieving genuine productivity growth may require short-term investment in transformation and could require double-running costs during the transition.
Measures of success. Productivity data is available from the Office for National Statistics (ONS), across healthcare, and the public and private sectors. The University of York's Centre for Health Economics estimates NHS productivity. The 10 Year Health Plan announced that a new 'Productivity Index' will be developed in 2025. Typically, multiple sources are reviewed and triangulated.
Overall assessment 🥵 Given the fiscal climate and need for reform, there is some rationale in setting a relatively ambitious target (2% per annum). However, in practice, it may prove overly stretching. For example, even within 2025/26 financial plans, approximately £1.5bn of efficiency savings already have known "risks" to delivery. 2025/26 will be a critical year for this target: If high productivity is achieved this can provide 'proof of concept'; but if productivity gains fall considerably short of 2% in 2025/26 it could undermine the target's credibility for subsequent years.

(6) CONSTRAINTS AROUND SOCIAL CARE, WORKFORCE AND CAPITAL

Economic and policy rationale. There is some justification for a lighter-touch approach to these three areas. Social care is not a key feature in the plan as the government has established a separate commission on social care, to report ultimately by 2028. For workforce, the NHS headcount has increased faster than healthcare activity since Covid-19, which weakens the argument for significant further expansion. Aside from committing to training "*thousands more*" GPs, the plan signals a relatively radical departure from previous workforce planning, emphasising new ways of working and future-proofing staff training, rather than significant additional staffing levels. (Further details will follow in the *10 Year Workforce Plan,* due later in 2025.) For capital, although the NHS capital budget will not grow further in real terms up to 2030, the starting point (in 2025/26) is still 30% higher than in 2023/24. The plan cites opportunities to leverage private capital, such as for new neighbourhood health facilities or car parks. In terms of overall rationale – particularly for workforce and capital – the plan sets out a future vision for healthcare, with less day-to-day reliance on staff-intensive acute healthcare providers, and instead, more community and home-based care, that is digitally enabled and supported through self-care.
Qualifications and risks. Social care capacity is a critical dependency for the NHS, as it facilitates hospital patient discharge. An estimated 13% of NHS beds are occupied by people waiting for social care or other out-of-hospital support. Without substantial policy decisions on social care until 2028 – when the commission will finally report – the NHS will continue to experience knock-on capacity challenges. For workforce, the plan projects that staff will work more efficiently, supported by AI. Whilst pilots have identified various benefits, technologies are still evolving, so there is some uncertainty around delivery. Capital constraints limit the NHS's ability to adequately refurbish its estate and facilities, leading to postponed activity, safety risk, and high maintenance expenditure. It could also limit the speed of expansion for new neighbourhood health centres (see above) and therefore the government's reforms.
Measures of success. For social care, delayed discharges provide an indication of ongoing constraints. For workforce, the demand-versus-supply gap can be monitored by triangulating NHS staff survey data (e.g. staff views on whether there are enough staff to meet demand) and vacancy data. However, both are imperfect measures as demand is challenging to observe precisely. For capital, the NHS Estates Returns Information Collection provides data on estate condition, including the value of the maintenance backlog.
Overall assessment 😳 The lack of social care reform in the short term presents a major constraint for the NHS. For workforce and capital, the plan's approach may be workable, but success will rely on rapid, implementable progress around virtual care, digitisation and workforce upskilling. The NHS's caution and aversion to change (albeit to support patient safety) may represent a significant hurdle.

NEXT STEPS AND DELIVERY QUESTIONS

The plan appears to be achieving its broad intention – to create "*energy and enthusiasm*". However, to generate success where previous strategies have struggled, focus should now shift to questions of delivery:

- **Risk management**: What is the backup plan if scarce resources are diverted? e.g. by staff strikes.
- **Tariffs**: Can outcome-based tariffs be reliably developed, noting historic challenges in this area?
- **Care continuity and health inequalities**: In practice, who will take decisions around any service decommissioning, and how can the NHS ensure stable, high-quality care in the interim?
- **Support**: Alongside greater accountability, how will the government support providers? For example, can it help to spread successful innovations, and ensure timely execution of the NHS App?
- **Individual incentives**: How can the public truly be incentivised to make healthier life choices?
- **Cross-government**: How will all government departments be accountable for prevention activities?
- **Learning lessons**: With many of the plan's themes harking back to historic policies and strategies, what must the NHS do differently this time, and what can be learned from outside the NHS, whilst being cognisant of the NHS's unique characteristics?

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