The Health Foundation | NHS Productivity Commission

Breaking the cycle

How to build a more productive NHS

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About the Commission

The Health Foundation launched the NHS Productivity Commission to provide evidence and identify solutions that can support productivity growth in the NHS in England.

The Commission was co-chaired by Anita Charlesworth, Senior Economic Adviser at the Health Foundation, and Tera Allas, a leading expert on economic growth, productivity and public policy. The eight commissioners – John Hall and Richard Murray (capital), Habib Naqvi and James Buchan (workforce), Catherine Davies and Matthew Bell (technology and innovation), Ben Gershlick and Rachel Wolf (transformation) – brought expertise from policy, economics and the front-line workforce. They were supported by a secretariat, based at the Health Foundation, and an expert advisory panel, which provided challenge and support, working with the commissioners and secretariat to develop policy solutions.

This report reflects the findings and conclusions of the Commission. Neither the report nor the related policy options papers necessarily reflect the views or position of the Health Foundation, or the organisations with which the co-chairs and commissioners are associated. You can access the Commission's content at www.health.org.uk/nhs-productivity-commission

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Foreword

The economist Herbert Stein said, 'If something cannot go on forever, it will stop'. The NHS is almost 80 years old and public support for its founding principles remains high. But the health service is at a critical juncture. To meet rising demand within its budget, it cannot keep doing more of the same.

The problem is not a lack of committed, motivated and talented people. Nor does the NHS want for examples of successful change. It is that improvement is often achieved despite its operating conditions, rather than because of them. To deliver high-quality patient care and remain on a sustainable footing, the NHS will need to work in a significantly more productive way. This must be hardwired into how the NHS operates.

'Productivity' can be a polarising term – often viewed as a purely financial issue or through the narrow lens of technical efficiency. Sometimes it is seen as exhorting hard-working staff to work even harder, in a system already under considerable strain. We must challenge this notion and reframe it. At its heart, productivity means achieving better health outcomes from the resources available. Building an NHS that serves patients well, now and in the future, depends on it.

Productivity is about creating a health system that consistently makes well-judged trade-offs to direct resources where they will have greatest impact on patient outcomes. This isn't a one-off or short-term task. Instead, it is ongoing: a productive system needs to continually adapt to meet the complex and changing needs of patients and to harness the potential of innovation.

Throughout our evidence-gathering and engagement, the Commission's approach has been to learn from what works (and doesn't work) in the NHS, high-performing health systems globally and other sectors of the economy. One fundamental point shines through: sustaining improved productivity will only happen if the NHS puts people at the heart of change. An engaged workforce and engaged patients aren't optional. They are fundamental to high performance and productivity.

The scale of the current challenge is widely recognised, not least in the government's ambitious target of 2% annual productivity growth. The prize is substantial and rapid advances in medicine and technology, including artificial intelligence (AI), create significant opportunities to improve outcomes and release capacity. The Commission has seen that

stakeholders understand both the urgency and what is at stake. But it is also clear that the NHS lacks a coherent system-wide approach to take on this challenge effectively.

This leads us to our overwhelming conclusion: the NHS is simply not set up to deliver sustained productivity growth. As currently designed, it often obstructs sound decision making and impedes efficient delivery. Take, for example, provider organisations, expected to raise productivity amid constant structural instability, hundreds of competing priorities, relentless short-term pressures and highly uneven capability to deliver change.

Significant productivity gains will not come from quick fixes. They cannot rely on the discretionary effort of staff or a handful of exceptional leaders. The system must make improving productivity the norm. This requires a redesign of the operating conditions – not another disruptive reorganisation, but a reset: greater stability, a shared purpose, clearer accountability, more freedom and stronger, enduring capability to improve care.

This report sets out how these underlying conditions can be created and why they matter. Our recommendations are deliberately focused on the few system changes that matter most – not another exhaustive list of programmes and initiatives. The recommendations are largely aimed at the centre, which must lead the transformation by setting a clear direction, aligning priorities and incentives, removing barriers and sustaining momentum. However, we recommend reading this report alongside the policy options papers authored by our commissioners, which provide more detailed analyses of the problems and put forward solutions for the four core long-term drivers of productivity: workforce, capital, technology and innovation, and transformation.

Thank you to the wide range of stakeholders whose insights and expertise have shaped this work. This spirit of collaboration remains essential.

If the NHS can unite around a shared goal – better health outcomes and patient experience from the resources available – then sustained productivity growth is within reach.

Tera Allas and Anita Charlesworth
Co-chairs, NHS Productivity Commission

Executive summary

Improving NHS productivity is not simply about delivering more activity or reducing costs. It means achieving better health outcomes and patient experience with the resources available, and continually finding better ways to deliver care.

At the outset, the Commission identified four drivers of productivity: workforce, capital, technology and innovation, and transformation. Within each driver, the NHS has substantial strengths. But across these areas, the same barriers to sustained productivity growth recur: short-term planning, fragmented accountability, excessive assurance requirements and insufficient capability to deliver change.

To overcome these barriers, this report sets out four changes in the conditions needed for sustained productivity improvement in the NHS:

- from **constant churn** to **stable direction**
- from **'priority overload'** to **focused accountability**
- from **excessive compliance** to **freedom to deliver**, and
- from **episodic change** to **capability to improve**.

These changes must not be layered on top of business as usual. They require the centre to remove as well as add. That means fewer reorganisations, priorities, controls, reporting requirements and short-term funding pots, creating the stability, freedom and headroom NHS organisations need to improve.

The productivity opportunity

NHS productivity in England has recovered much of the ground lost during the pandemic, but it remains below its pre-pandemic level, and the NHS continues to face profound operational challenges and low levels of public and staff satisfaction.

There is substantial scope to improve outcomes within the funding already available to the NHS. Our analysis suggests that if the NHS in England achieved outcomes closer to the best-performing comparable health systems, without spending more each year, it could potentially result in:

- **18,500–20,600 fewer deaths each year from treatable causes**
- **2.5 to 4.5 additional years that people spend in good health on average.**

Productivity is also critical for the public finances. In the UK, health care spending is already equivalent to 8.3% of GDP, with the Office for Budget Responsibility (OBR) projecting this could rise to 9.5% by 2040/41 and 10.6% by 2050/51. If the NHS can respond to rising pressures by harnessing the potential of its staff, buildings and technology more effectively, spending could instead rise to around 8.7% of GDP by 2040/41. At first glance, the gap between these two paths – 0.8 percentage points of GDP – might not leap off the page. But it is equivalent to roughly £33bn a year in today's prices, or around £460 for every person in the country per year. By 2050/51, this figure would be £83bn a year (or £1,130 per person).

Productivity is therefore central both to improving care and to the long-term sustainability of the NHS and wider public finances. The issue is not whether the NHS should pursue higher productivity, but how.

How productivity improves

Productivity can be boosted through different routes: by improving current services, changing how resources are combined, shifting resources towards higher value care and redesigning care so that unnecessary activity is avoided altogether.

The early focus of NHS productivity recovery has been on running existing services better. This is vital and there remains room to improve. But it will not be enough on its own.

There are several structural barriers to higher productivity. Underinvestment in capital, technology, data and improvement capability has left bottlenecks and underused capacity. Too much care is organised around hospital-based services rather than primary care and prevention. Services must be redesigned to meet changing patient needs, including the growing number of people living with multiple or complex conditions. The NHS will need to focus on all routes to sustain productivity growth.

Why the NHS struggles to improve productivity

The NHS does not lack opportunities to improve productivity across the ways we describe, yet it struggles to implement and sustain these solutions. Much is already known about the specific barriers to productivity within each driver, but it has proven more difficult to gain a deeper understanding of why they recur.

Our central diagnosis is that these barriers have common causes. Short-term planning and organisational churn make it difficult to invest for the long term. Numerous targets and priorities fragment attention, with too little accountability for sustained improvements in outcomes. An excessive burden of regulation and assurance consumes leadership and staff time, pulling effort towards compliance. Management, operational and analytical capabilities are too thinly spread.

These arrangements have developed for understandable reasons, often in response to genuine performance problems, financial pressures and failures in care. But their combined effect is to undermine productivity and create a self-perpetuating cycle: short-term pressures reduce the capability to improve productivity, prompting additional scrutiny and intervention that weaken capability even further. Breaking this cycle requires more than design tweaks or changes to incentives. It requires a different approach.

Four conditions for sustained productivity improvement

To create an environment in which the NHS can boost long-term productivity, the Commission identifies four core conditions for change, backed by 10 recommendations.

We deliberately focus on the few system changes that matter most. As our recommendations are system-level, they are largely aimed at the Department of Health and Social Care (DHSC) (which we assume will absorb the functions of NHS England, in line with current legislative plans). Across all four conditions, change should be shaped with patients and staff, rather than being imposed.

1. From constant churn to stable direction

Many of the changes most likely to improve productivity will take years to deliver. Yet NHS organisations operate through short-term budgets, fragmented funding arrangements, changing priorities and repeated organisational reform.

The Commission recommends that:

- **The Treasury and DHSC should establish a stable, multi-year planning and investment framework to support long-term**

productivity growth. From the 2027 Spending Review, a rolling 5-year framework should align revenue funding, capital, workforce planning, digital investment and payment policy, replacing reliance on short-term funding pots and giving providers the confidence to invest in sustained improvement.

- **Government should quickly settle the outstanding structural organisational issues relating to the Health Bill and devolution, and then refrain from further major reorganisation.** This would enable leaders and staff to focus on improving services and productivity, rather than responding to repeated organisational change.

2. From 'priority overload' to focused accountability

A more productive NHS will need to be clearer about the outcomes it seeks, while giving organisations and teams greater flexibility over how these are achieved, with staff and patients engaged in service redesign. Accountability should be tight on ends but substantially less prescriptive about the means, with fewer conflicting signals given to systems.

The Commission recommends that:

- **DHSC should set a clear productivity-focused purpose: achieving better outcomes within the resources available. This should be backed by a small number of national goals and clear minimum standards.** National goals should be rebalanced away from acute care and increasingly focus on outcomes. Minimum national standards should be based on a refresh of the NHS constitution standards, informed by clinical guidance and public engagement. Performance oversight should be trimmed back to focus on these minimum standards, alongside finances and staff engagement as leading indicators of sustained improvement. Intensive intervention should be reserved for significant or persistent failure.
- **The NHS should devolve greater authority and accountability for improving services and productivity to local systems.** Integrated care boards, working with mayors and strategic authorities, should identify a small number of outcome-focused priorities for their populations. Providers and front-line teams should lead improvement in practice. Regions should have a clear and durable mandate to enable improvement – benchmarking performance, spreading effective practice, coordinating action and supporting organisations that are off track – rather than overseeing performance alone.

- **DHSC should extend and improve outcomes measurement so that performance can be better assessed across the NHS.** There should be greater weight nationally and locally on outcomes and patient experience, with DHSC supporting tools for consistent and comprehensive recording of high-quality data. Systems, providers and boards should have more scope to use these data to guide improvement and resource allocation. Reporting needs to be transparent so the public can understand performance. The NHS in England should also participate in OECD's PaRIS programme to enable international benchmarking.

3. From excessive compliance to freedom to deliver

The NHS should distinguish more clearly between requirements that provide necessary safeguards and those that are duplicative, obsolete or disproportionate. Realising the potential of new models of care and technologies, including AI, requires changes in how care is delivered and credible evidence of their effectiveness in practical settings.

The Commission recommends that:

- **DHSC should systematically reduce requirements that divert time and capacity from improving care, with a dedicated unit established to drive change.** An office for NHS simplification should identify and remove avoidable burdens across regulation, guidance, reporting, financial controls, funding conditions and approval processes, and act as a gateway for significant new requirements to ensure they are necessary and proportionate.
- **DHSC should create a rapid national 'test-and-learn' approach to identify, evaluate and scale more productive models of care and emerging technologies.** Providers and systems should test new workforce and service models, pathway redesigns and technologies through coordinated evaluation, replacing repeated local piloting with shared learning and clear decisions to stop, adapt or scale. This should include a tailored approach for evaluating and adopting AI at pace.

4. From episodic change to capability to improve

Freedom to act is of limited value if organisations lack the capability to diagnose problems, redesign services, implement solutions and sustain productivity improvement.

The Commission recommends that:

- **DHSC should develop and implement a workforce plan for the leadership, management and improvement capability needed to support productivity growth.** This should recognise operational, analytical, digital, HR and commercial roles as essential to care. It should also rebuild graduate, clinical leadership and senior talent pipelines, and strengthen practical operational and improvement skills across the NHS. The new College of Leadership and Management should help deliver this.
- **Providers should pool and draw on scarce expertise across their region to support productivity improvement.** NHS regions should convene and fund shared capability in areas such as analytics, evaluation, digital implementation, operational improvement and capital delivery, while providers retain responsibility for identifying priorities and leading change.
- **DHSC should strengthen data standards and mandate interoperability.** A practical roadmap, aligned with the single patient record, should set common standards, clear adoption deadlines and how compliance will be tested and enforced in practice. Relevant standards should be made binding on NHS organisations and suppliers, backed by shared commercial and technical support for providers.

Delivering lasting change

Maintaining momentum requires sustained ownership and commitment at the highest levels of government and the NHS, including resisting the instinct to respond to failure with ever tighter control. This means being honest about existing challenges, while recognising that better access, outcomes and quality are possible with a different approach.

Our recommendations would mark a fundamental shift in how the health service operates, but are also practical and would not require another disruptive structural reorganisation. They support longstanding ambitions around prevention, care closer to home and better use of technology.

Many of these changes will take time to deliver, but a more productive NHS is within reach. This report sets out the conditions needed to break the current cycle and deliver lasting change.

Diagnosis

The NHS has struggled to translate increased expenditure and staff levels into better access, outcomes and experience for patients and staff. Without sustained productivity improvement, it will find it increasingly difficult to meet changing health needs and improve care within the resources available.

The NHS has many of the ingredients needed to be one of the world's most productive health systems, but systemic barriers are preventing sustained productivity improvement:

Constant churn
Short termism and a lack of effective planning

Priority overload
Too many targets, not enough focus on outcomes

Excessive compliance
Heavy assurance burden that crowds out effort and initiative

Episodic change
Insufficient investment in the capabilities needed for improvement

Vision

A health service that is routinely able to improve itself, turning its extraordinary assets into better health, better care and better value over the decade ahead.

NHS staff:

- are aligned and motivated around clear goals
- feel supported by good leadership, information and tools
- have the agency to adapt, learn and improve.

Conditions and recommendations for improving productivity

From constant churn to stable direction

- The Treasury and DHSC to establish a **multi-year planning and investment framework** to support long-term productivity growth
- Government to quickly **settle outstanding structural organisational issues** relating to the Health Bill and devolution, and then **refrain from further major reorganisation**

From priority overload to focused accountability

- DHSC to set a **productivity-focused purpose**: achieving better outcomes within the resources available. This should be backed by a small number of **national goals and clear minimum standards**
- The NHS to **devolve greater authority and accountability** for improving services and productivity to local systems
- DHSC to **extend and improve outcomes measurement so that performance can be better assessed** across the NHS

From excessive compliance to freedom to deliver

- DHSC to **reduce requirements** that divert time and capacity from improving care with a **dedicated unit established to drive change**
- DHSC to create a **rapid national 'test-and-learn' approach** to identify, evaluate and scale productive models of care and emerging technologies

From episodic change to capability to improve

- DHSC to implement a **workforce plan** for the **leadership, management and improvement capability** needed to support productivity growth
- Providers to **pool and draw on scarce expertise** across their region to support productivity improvement
- DHSC to **strengthen data standards** and **mandate interoperability**

Introduction and context

> ‘Productivity and talking about productivity has become [...] unavoidable.’
>
> Francesca Colombo, Head of OECD Health Division (evidence event)

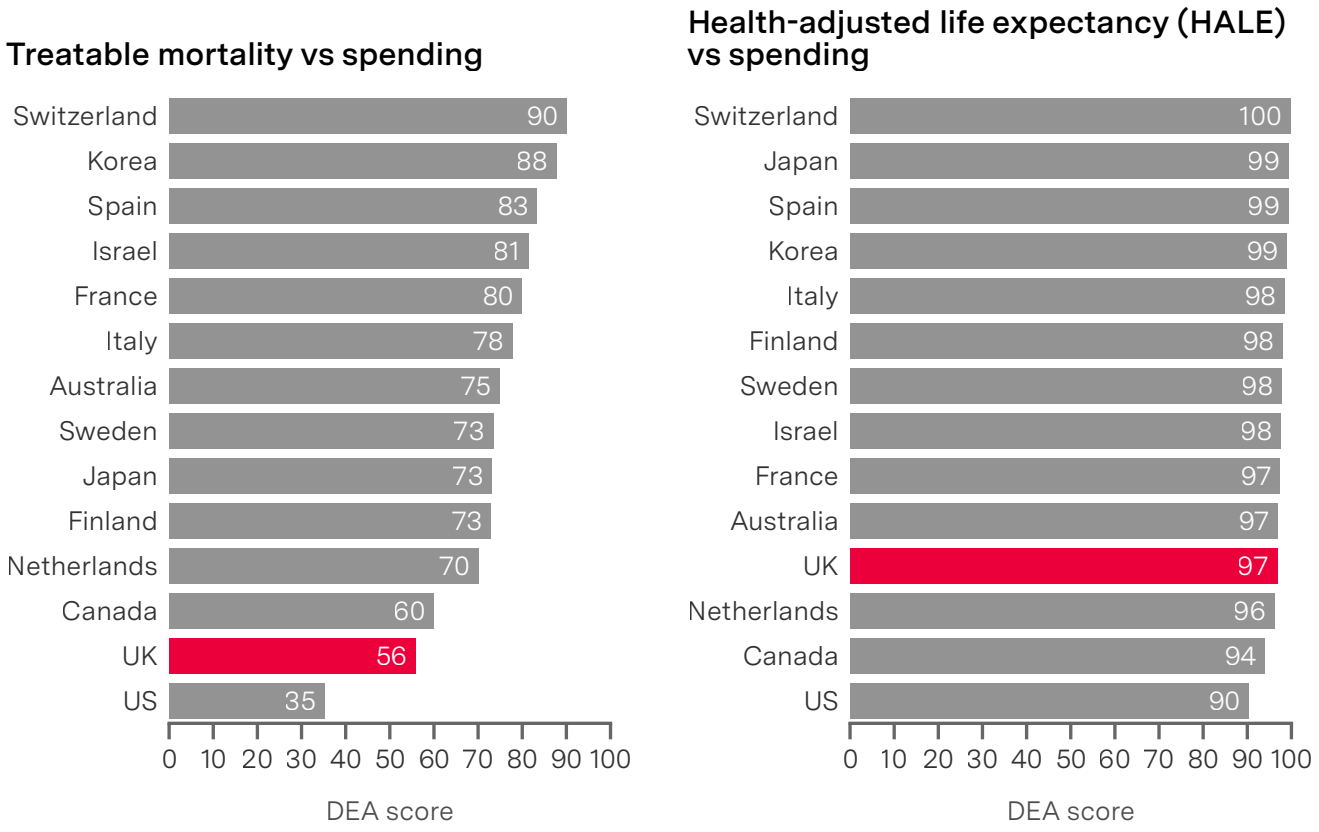
Productivity is not just delivering more activity, but maximising health care value within the resources available (see Box 1). With rising demand for health care, low public satisfaction and growing pressure on public finances, it is more important than ever that the NHS in England uses the available resources to deliver the best possible outcomes for patients.[1,2,3]

In our first report, *From diagnosis to delivery* (2025), we examined the deterioration in NHS productivity during the COVID-19 pandemic and identified four drivers of productivity: workforce, capital, technology and innovation, and transformation.[4] Since this deterioration, productivity has begun to recover steadily.[5]

This recovery matters, but it does not mean the productivity challenge has been solved. The NHS still struggles with some of its most persistent challenges, such as meeting waiting-time standards and coordinating care for people with multiple conditions.

There is substantial scope to improve across a range of health outcomes within available resources. Causal estimates are challenging, but our analysis across 14 high-income countries suggests that if England matched its highest performing peers, this could result in improved outcomes within the existing budget. This could be equivalent to around 18,500–20,600 fewer treatable deaths each year, alongside people spending on average 2.5–4.5 additional years lived in good health (Figure 1).

Figure 1: The UK is a low performer on many productivity measures using health outcomes
Comparison of OECD countries by treatable mortality vs spending and health-adjusted life expectancy (HALE) vs spending, ranked on a performance score against the best possible performance (100), 2023



Source: NHS Productivity Commission analysis of OECD Health Statistics, 2023, IHME Global Burden of Disease 2023, ONS, England treatable-mortality count, 2023. · DEA = data envelopment analysis. Selected peer OECD countries. For full methodology, including risk adjustment, see 'Annex: technical notes'.

Higher NHS productivity can also reduce the pressure caused by rising health care spending on taxes, borrowing and other public services. Health care is already central to the public finances, accounting for around £1 in every £5 spent on public services in 2025/26.[6] The fiscal context has also become more challenging since this Commission started, with commitments to increase defence spending, the prospect of much higher adult social care spending, and the tax burden set to reach a post-war high of 38.5% of GDP by 2030/31.[2,7,8]

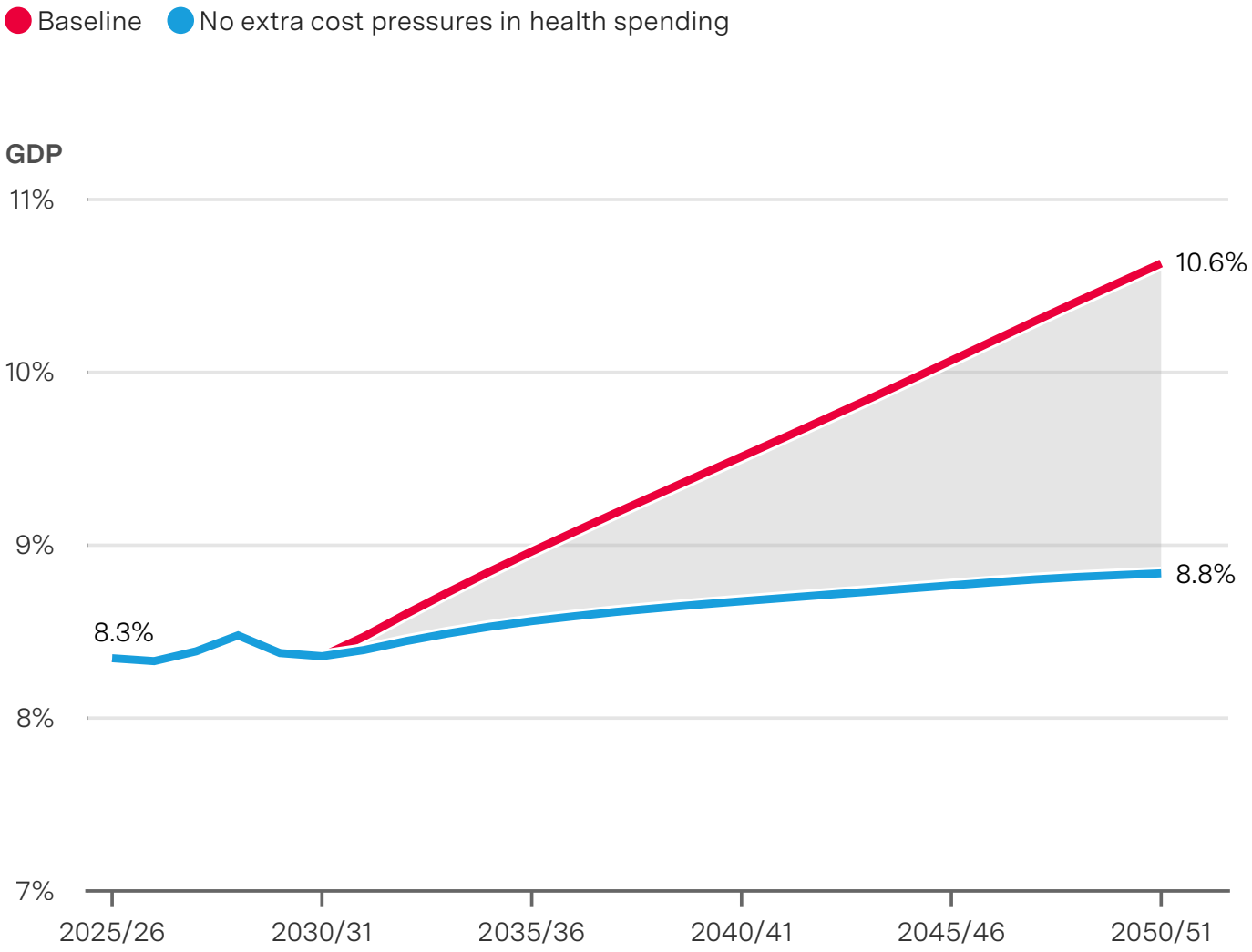
The Office for Budget Responsibility (OBR) projects health spending could rise further, from the equivalent of 8.3% of GDP in 2025/26 to 9.5% of GDP by 2040/41 and 10.6% by 2050/51 under its baseline scenario (Figure 2).[2] If additional cost pressures were avoided – for example, because technology, service redesign and higher productivity allowed

the NHS to better meet rising need – spending would be 8.7% of GDP by 2040/41, or 8.8% by 2050/51. That difference – 0.8% of GDP by 2040/41 – is equivalent to roughly £33bn a year in 2025/26 prices, or about £460 for every person in the UK each year. By 2050/51, this difference increases to £83bn a year (or £1,130 a person).

Productivity is therefore central both to improving care and to the long-term sustainability of the NHS and wider public finances. The issue is not whether the NHS should pursue higher productivity, but how.

Figure 2: If additional cost pressures were avoided, health care spending equivalent to 1.8% of GDP could be saved over the next 25 years

UK health spending projections as a percentage of GDP, by scenario: baseline vs 'no extra cost pressures', 2025/26 to 2050/51



Source: Office for Budget Responsibility (OBR), Fiscal risks and sustainability report, July 2026. · For full technical notes and scenarios methodology, see 'Annex: technical notes'.

About this report

Across the Commission's work, we found common barriers that cut across the main drivers of productivity. Planning in the health service is too short term and unstable. Accountability is fragmented and overloaded. Regulation, assurance and approval processes create unnecessary friction. And the management, operational, digital and analytical capabilities needed to deliver change are too thinly spread.

Throughout our work (see Box 2), we have seen that the NHS does not lack commitment, ideas or examples of better practice. It has substantial strengths on which it can build: skilled staff, public support, rich data, national scale and deep clinical expertise. Rapid advances in technology, including AI, could create further opportunities to improve productivity. But to consistently turn these strengths into better care, the NHS needs to build the conditions for sustained productivity growth.

This report sets out how policymakers and system leaders can create these conditions. Our recommendations are designed to support local effort, professional leadership and wider policy ambitions. Implementing these recommendations will help the NHS deliver better outcomes for patients, a better working environment for staff and greater value for the public.

To accompany this report, we are also publishing four policy options papers. These underline that improvement is urgently needed in the way the NHS plans and manages its workforce, capital investment, approach to innovation and use of technology, and transformation. While changes within each of these drivers are necessary, on their own they are unlikely to be sufficient to transform productivity.

Box 1: Defining and measuring productivity

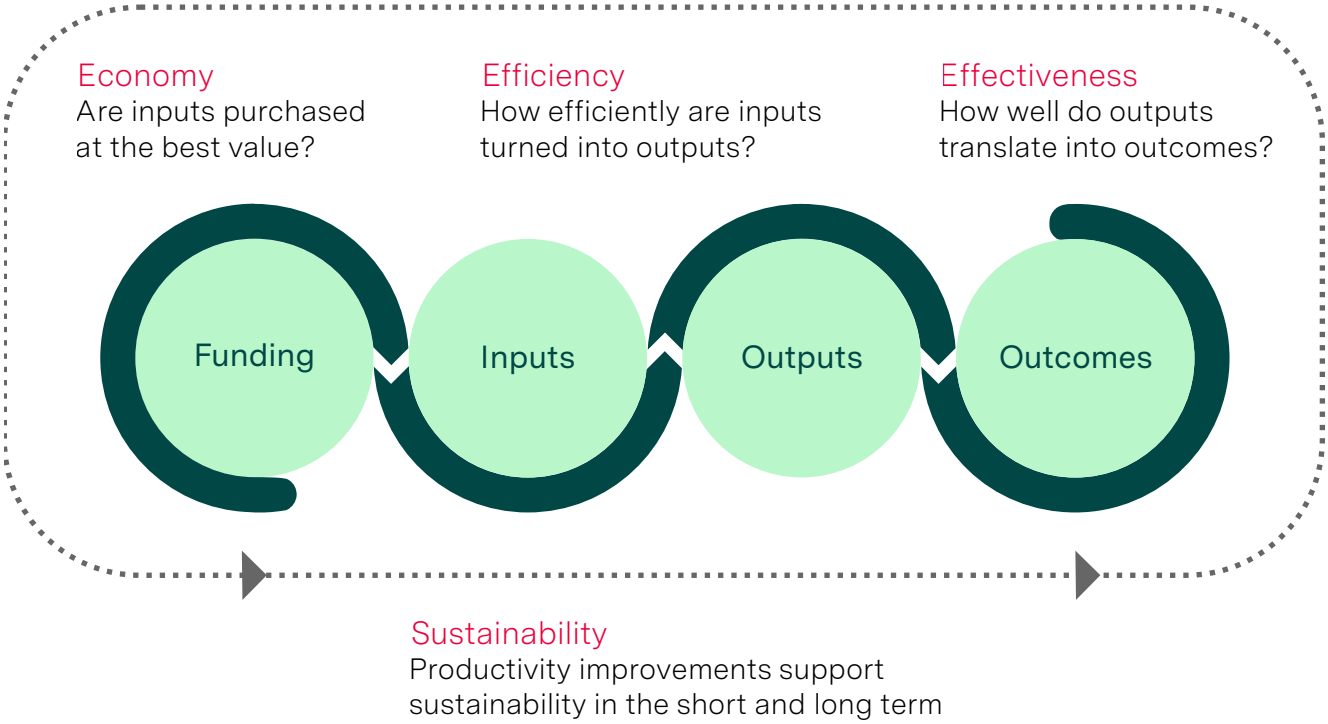
We define productivity as the health care value for every pound invested. In our first report, we distinguished between its components: economy (whether inputs are purchased at best value), efficiency (how well inputs are converted into outputs) and effectiveness (the extent to which care improves outcomes) (see Figure 3).

In practice, measuring health care value is challenging. Many of the outcomes that matter most to patients and the public are difficult to observe consistently or to quantify and attribute to NHS care. As a result, existing productivity measures developed by organisations such as the ONS, the Centre for Health Economics and NHS England capture something closer to efficiency. They assess how well the NHS converts inputs (such as staff and equipment) into outputs (such as treatments).

These measures seek to move beyond simple activity counts – for example, by weighting activities by cost as a proxy for value. This is a reasonable assumption and easy to apply, but by no means perfect. It can also create perverse incentives. Costs are currently better captured in acute settings than non-acute settings, while care delivered is easier to value than activity avoided. Together this can create a signal that the health system should absorb more complex care in hospitals when, in fact, there should be greater focus on preventing ill health or moving some care into settings closer to home.

The ONS and Centre for Health Economics also adjust for some aspects of quality such as waiting times, admissions and patient outcomes where possible. Nevertheless, they remain imperfect proxies for health care value. We use these measures as the best available indicators for productivity, while recommending steps that could be taken to align productivity measurement with outcomes and value.

Figure 3: Defining system productivity



Source: Adapted from Aldridge S, Hawkins A, Xuereb C. Improving public sector efficiency to deliver a smarter state, UK government, 2016. · Contains public sector information licensed under the Open Government Licence v3.0.

Box 2: Our approach

The Commission structured its work around the four drivers of productivity. In pairs, our commissioners produced four policy options papers, each addressing a different driver. This report and the policy options papers were informed by:

- More than 100 stakeholder interviews and meetings, including with those working across the health and care system.
- Desk research and literature reviews to understand learning from past and current initiatives, nationally and internationally.
- Visits to NHS sites in England to observe care pathways, workflows, digital infrastructure, estates constraints and front-line improvement work.
- An open call for evidence, which generated 125 submissions, offering insights from a range of respondents, from front-line staff to patients.
- Evidence sessions with experts on learning from other health systems, other parts of the economy and best practice in the NHS.
- Sessions with patients and service users, clinicians and others to understand their experiences and their ideas.

Reframing productivity

> ‘Productivity in the NHS in England will rise only if we treat it as better outcomes and experience per pound spent, not simply more activity.’
>
> Call for evidence respondent

Productivity can be seen as a cold, technical agenda associated with cost-cutting, targets and tasking already stretched staff with working even harder. The Commission takes a different view. A more productive health system is one that can achieve better outcomes and experience within the resources available.

Productivity improvement is fundamentally about change: continually finding better ways to use available resources to improve care and having the ability to put those changes into practice. That can mean removing waste and friction from the way care is delivered today, changing how resources are combined, shifting resources towards higher value care, or developing different models of delivery.

The challenge is making that change happen. The NHS in England, like all advanced health care systems, is a complex system in which decisions are distributed across national bodies, organisations, professions, teams, patients and carers, who act in different contexts, under varying constraints, and interact in ways that may be hard to predict.[9]

In arriving at our recommendations, the Commission has therefore been guided by five principles for how productivity improvement should be pursued in a complex system. Taken together, they imply a more positive model for productivity: shared purpose rather than compliance, stewardship rather than each part of the system optimising itself, timely feedback rather than remote control, and learning rather than prescription.

1. Be clear on outcomes and value

The wider approach to productivity should begin with what matters to patients and staff: better health, better experience, timely access and fewer avoidable demands on their time, all within available resources. Activity and cost remain important, but they are means rather than ends.

2. Treat productivity as a people agenda

In the NHS, productivity is delivered by people. Front-line staff understand how care actually works in their context, including the repeated forms,

missing information, unnecessary handovers and poorly designed processes that waste time. Patients experience pathways as a whole and can identify gaps that are invisible from within individual teams or organisations. A solution to these challenges is more likely when those closest to care help identify problems and shape redesign.

3. Build the motivation for continuous improvement

Most NHS staff are motivated by helping patients and doing a good job. This is a powerful foundation, but motivation to provide good care does not automatically translate into improving how care is delivered.

Purpose, autonomy, psychological safety, recognition and opportunities to learn can help direct professional motivation towards continuous improvement.[10] Accountability, targets and financial incentives also have a role, but should build on rather than undermine that motivation. Success in improving productivity should be visibly celebrated.

4. Build the capability to learn and improve

Teams need time, skills, information, supportive leadership and permission to act. They should test ideas, learn from setbacks and adapt approaches to local circumstances. Timely, credible and usable information can be as influential as financial rewards.[11]

5. Steward shared resources and make the trade-offs explicit

The NHS cannot do everything. An additional test, referral or review may be rational for an individual patient, but collectively these decisions can crowd out care that could deliver greater benefit overall. Optimising individual organisations or services does not necessarily maximise health outcomes or patient experience across the system as a whole.

This entails difficult trade-offs. Improving productivity often requires some kind of change, whether that is for resources to move, roles to change or services to close. Avoiding making these choices also has consequences. Decisions should therefore be transparent, evidence informed and shaped with patients, staff and the public.

This is politically challenging, but the Health Foundation's polling with Ipsos (published August 2026) suggests the public accepts the need for trade-offs. When asked, a clear majority of the public supported focusing

NHS resources on treatments and services most likely to improve patients' health or quality of life, even if that means reducing the availability of some treatments and services that bring limited health benefits. Support remains strong whether this is framed in terms of prioritising services (71%) or stopping lower value care (67%).

Productivity should begin with what matters to patients and staff: better health, better experience, timely access and fewer avoidable demands on their time.

The case for a bolder approach

NHS productivity: what the numbers show

22%

fall in productivity at the onset of the pandemic.

6%

gap remains between pre-pandemic productivity and the latest annual ONS estimate for 2023/24.

0.6%

average annual growth in health care productivity in England before the COVID-19 pandemic.

2%

annual productivity target set for the NHS over the Spending Review period, 2025/26 to 2027/28.

3.5%

annual growth in productivity in NHS trusts in 2025/26.

£460 per person

the amount that could be saved each year by 2040/41 if higher productivity growth puts health spending on a lower path.

18,500–20,600

fewer treatable deaths each year within current spending if the NHS matched the best-performing countries.

11%

the increase in acute productivity that would be achieved by raising lower productivity acute providers to the current average level.

1.9 million

additional admitted pathways that could be completed if activity per consultant rates matched 2015 levels.

Current policy focus on productivity

When NHS productivity, as measured by the ONS, fell sharply at the onset of the pandemic and remained 6% below its pre-pandemic peak in 2023/24, it wiped out a decade of productivity growth.[12] This prompted a renewed focus on efficiency.

The 2025 Spending Review set an ambitious target of 2% annual productivity growth, much higher than the 0.6% annual average growth seen before the pandemic. NHS England published a productivity plan with actions for 2026/27 and longer term ambitions.[5,13]

The first phase of the NHS productivity plan has focused heavily on better day-to-day management of services, financial control, reducing variation and improving flow.[5] This echoes past NHS efficiency programmes, such as the Nicholson Challenge and the Carter Review (2015), which suggested large savings could be made in the NHS.[14,15,16]

Measured productivity has improved, with acute hospital productivity growing faster than the government's 2% annual productivity target in 2024/25 and 2025/26, with faster improvements across all trusts according to recent data (Table 1).[17] That said, these gains have relied heavily on low input growth, which may not be sustainable.

Table 1: NHS trust productivity growth by sector (2025/26)

Sector	Input growth	Output growth	Productivity
Acute and specialist	0.1%	2.7%	2.6%
Community	-0.3%	-1.2%	-0.9%
Mental health	-0.4%	7.7%	8.2%
Ambulance	-1.0%	5.1%	6.1%
All providers	**0.0%**	**3.4%**	**3.5%**

Source: NHS productivity growth estimate, March 2026 (final revised). · NHS trusts only; primary care is not included.

Recent productivity gains matter. But productivity does not improve only by running existing services more efficiently. It can also improve by changing the resources used, directing them towards higher value care, or redesigning care altogether.

Four routes to improving productivity

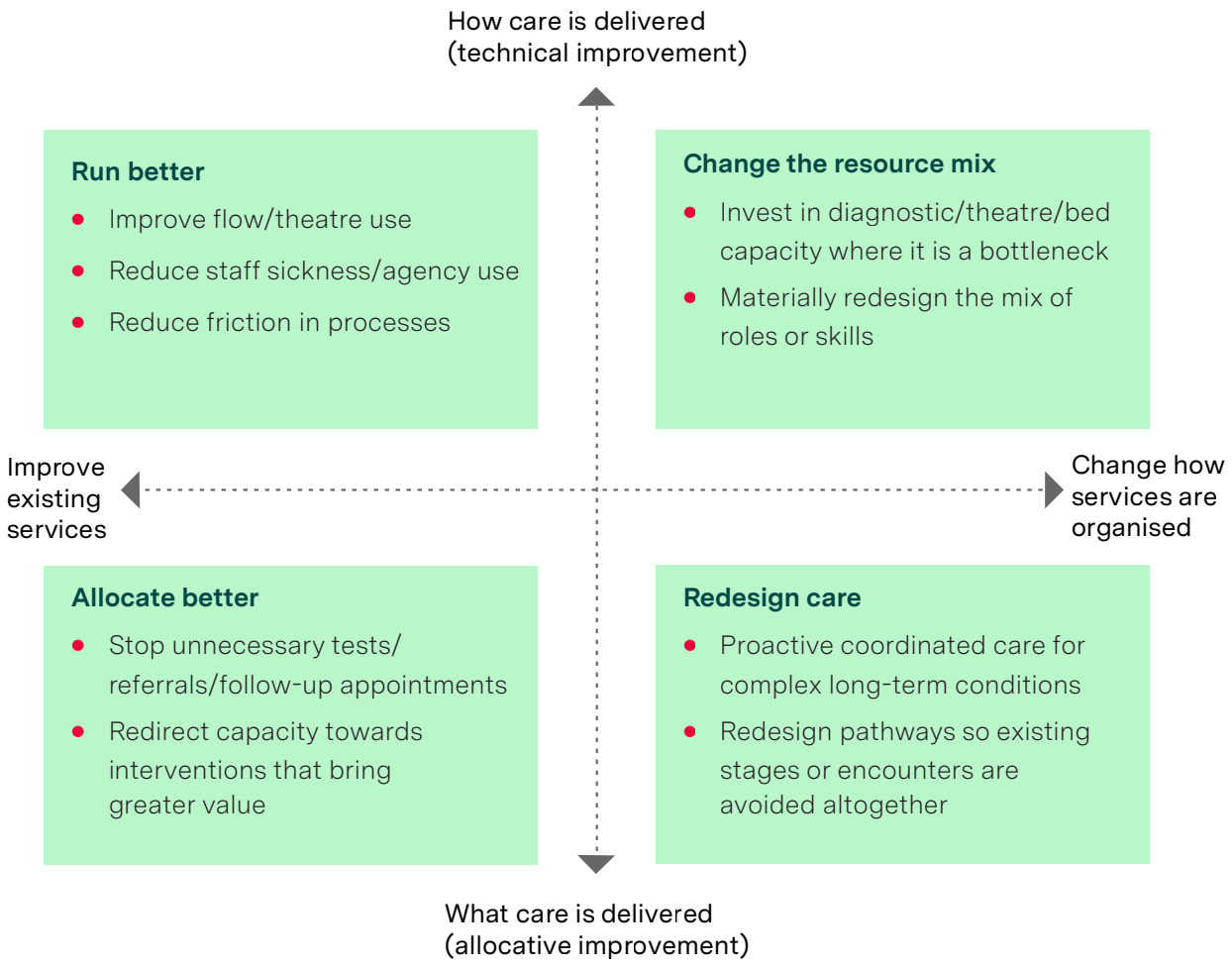
There is an important distinction in productivity improvement between technical and allocative efficiency. Technical improvements are mainly about economy and efficiency: purchasing inputs at the best value and turning them into outputs with minimal waste. Allocative improvements are more about effectiveness: directing resources towards the care that generates the best health outcomes and value for patients and the public.

Productivity improvement can also vary in pace or scale. In any industry or sector, productivity growth can emerge gradually, as organisations improve existing processes. Or it can occur through more fundamental shifts in how goods or services are produced, or when new models of delivery make a higher level of productivity possible – such as the logistics revolution in retail or the emergence of low-cost airlines.[18,19]

This gives four different routes to improving productivity (Figure 4). Across our call for evidence, interviews and evidence sessions, we heard examples spanning all four.

> 'If we want fundamentally different outcomes, we have to redesign the wiring of the system. This is not incremental improvement – it is transformational change.'
>
> Stella Vig, Deputy National Medical Director for Secondary Care, NHS England (evidence event)

Figure 4: Four routes to improving productivity



1. Run better

Our analysis suggests that if lower productivity acute providers were to improve to the sector's current average level of productivity, this could boost overall acute efficiency by around 11%. But performance data show where to look, not what to fix. We repeatedly heard that data should prompt enquiry, rather than blame.

We heard opportunities including applying supply chain approaches to improve patient flow, reducing unnecessary variation in procurement, and tackling staff sickness absence and missed appointments. Many of the most successful case studies highlighted the importance of engaging staff in identifying solutions.

2. Change the resource mix

Productivity depends not only on how much resource the NHS has, but how different resources are combined. Inputs across the NHS are planned through different processes and over different timescales, which can lead to incoherent decisions.[20] Our updated analysis of capital per worker in NHS trusts shows it fell by 30% between 2010/11 and 2024/25.[21]

Clinical staff are constrained unless the wider resources needed to deliver care – beds, theatres, diagnostics, admin support and management – are in place.[22] We heard that poor IT wastes clinical time, limited estate and equipment constrains activity, and gaps in administrative support shift additional work onto clinicians. More than half the surgical workforce report theatre access is a major challenge.[23]

3. Allocate better

Even efficient individual services can remain unproductive if resources are concentrated on forms of care that produce less value than the alternatives. Productivity therefore depends on shifting resources towards higher value care.

We heard there are widespread opportunities for shifting to higher value care within pathways. For instance, modelling of back pain services in Mid-Nottinghamshire suggested that health gain could increase by around two-thirds within the same budget.[24] In Italy, reorganising diabetic foot care around earlier and more coordinated treatment reduced costly hospital care while improving outcomes.[25] Other opportunities we heard include reducing low-value tests and expanding community services, for example within eye care. More broadly, greater investment in prevention and primary care could support higher value care. Yet between 2015 and 2024, the number of fully qualified GPs fell on a full-time equivalent basis, while general practice's share of NHS spending declined.[26,27]

4. Redesign care

Sometimes improving productivity requires redesigning the way care is delivered, rather than simply moving resources from one service to another. The reorganisation of stroke care around specialist hyperacute centres provides a prominent example.[28,29,30,31,32]

This is particularly important as the NHS responds to rising levels of multimorbidity, frailty and long-term conditions. Fragmented or poorly designed services can create more work, sometimes referred to as 'failure demand', because the system has failed to do something earlier on.[33] We heard examples across conditions like diabetes, frailty and end-of-life care where this leads to avoidable attendances, admissions and lengthy hospital stays. One consequence is delayed discharges from hospital, with around 1 in 7 hospital beds occupied by patients medically fit for discharge at an estimated direct cost of £2.7bn.[34,35]

There is also a time burden. Research published by the Royal College of General Practitioners found that the average cost of hidden and avoidable workload is equivalent to £410 per GP per day in England.[36] Patients and families also absorb significant time and effort navigating fragmented services when the system does not work for them.[37,38]

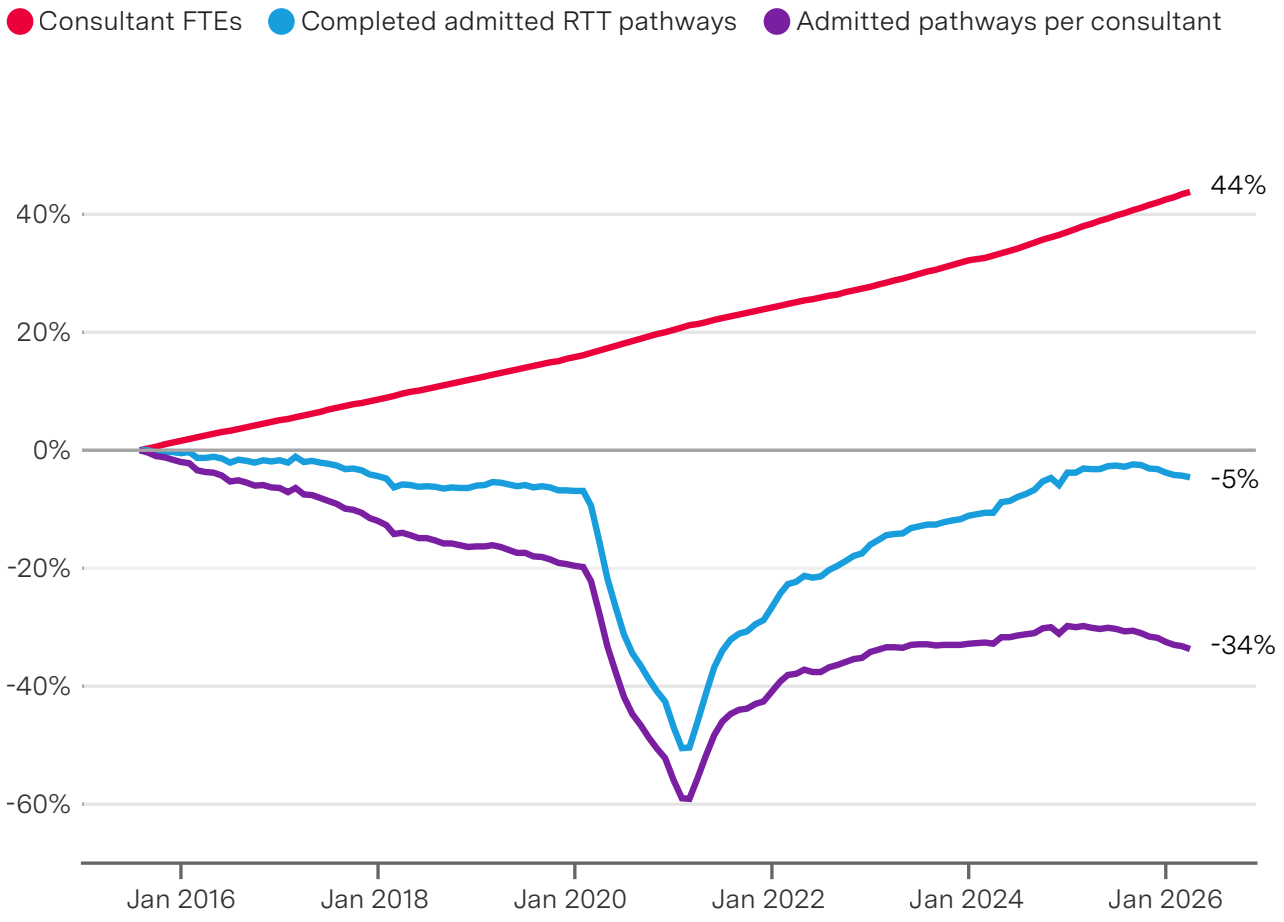
These are not four separate or sequential approaches. The NHS needs to be able to pursue all four routes, although the right balance will depend on the opportunities and constraints for improving productivity.

Why 'running better' is not enough

Health Foundation analysis suggests many barriers to productivity are systemic rather than confined to a small number of poorly performing organisations.[39] The relative gap between trusts has remained strikingly stable since before the pandemic, while efficiency fell across the board including among higher performing trusts. This suggests structural barriers to productivity growth, which will limit the scope of operational improvement.[22,23]

These pressures are highly visible in acute hospitals, where consultant numbers have grown substantially, even as full-time GP numbers have fallen, but complementary capacity has not kept pace. General and acute bed numbers have been broadly flat, occupancy is high and we heard repeatedly about constraints in theatres, diagnostics, administration and infrastructure. Despite a 44% increase in consultants (full-time equivalent), the number of admitted patient pathways completed off the referral-to-treatment (RTT) waiting list remained 5% lower in 2025/26 than in 2015/16 (Figure 5).

Figure 5: Consultant growth has outpaced planned admitted hospital activity
Percentage change in number of consultants, completed referral-to-treatment (RTT) pathways and admitted pathways per consultant vs August 2015, England, August 2015–April 2026



Source: Consultant-led Referral to Treatment Waiting Times Data 2026–27, NHS Workforce Statistics, April 2026.
· Completed pathways uses NHS Referral to Treatment data 'no. of pathways (all) with estimates for missing data'. Admitted pathways calculated on a cumulative 12-month basis, consultant FTEs is a rolling 12-month average. For full technical notes, see 'Annex: technical notes'.

Had admitted RTT pathways per consultant remained at their 2015 level, the NHS would have completed around 1.9 million more admitted pathways in 2025/26 (around 5.6 million instead of 3.7 million). That additional annual flow would be more than enough to treat all the 1.2 million people currently waiting for hospital treatment with a decision to admit.

There are caveats to this argument. Growing numbers of patients with complex needs are not captured. Hospital beds and other resources are not the only factor constraining consultant activity, and we heard that the system has been slow to adapt to changing working patterns, including

more flexible working, limiting opportunities to maximise direct clinical care. Regardless, the prize is one we should be aiming for: a system that can continually improve performance against key goals.

Policy must support all four routes for improving productivity

A renewed focus on productivity has strengthened accountability and contributed to improvements in financial control and some operational practices. These gains matter and the next phase of productivity policy should continue to help services run better. But structural pressures facing the NHS mean that this will not be enough to sustain productivity gains over time.

Sustained productivity improvement will also require the NHS to pursue alternative routes: changing the mix of resources used to deliver care, moving resources away from lower value uses and towards higher value ones, and developing fundamentally different ways to deliver care where existing pathways no longer meet patients' needs.

This is reflected in the three shifts set out in the 10-Year Health Plan and much of the government's wider policy direction (Box 3).[40] It is also recognised in the longer term direction of the NHS productivity plan, which extends beyond operational recovery towards technology-enabled transformation and new models of care.[5] The plan also recognises the need to develop complementary measures of productivity that can better reflect these gains.[41]

Box 3: The wider policy context

The productivity plan sits within the government's wider reform agenda. In the near term, the government has committed to meeting NHS constitutional standards for elective waits by the end of the parliament. Over the longer term, the 10-Year Health Plan proposes three shifts: from hospital to community, from analogue to digital and from sickness to prevention.[40]

The detail of delivery is becoming clearer. Neighbourhood health is intended to organise services more effectively around people and populations. Integrated care boards are expected to act as strategic commissioners. Advanced foundation trust status and new contractual models, including integrated health organisations (IHOs), are intended to give some providers greater responsibility for resources, pathways and population outcomes.[42]

Alongside these reforms, the government is developing a new 10-Year Workforce Plan. The plan is yet to be published but is expected to reflect the potential for technology and new models of care to change roles, skill mix and workforce requirements.[43] Health Foundation analysis points to the need for the plan to make realistic assumptions about future demand and the workforce needed to meet this, in particular around strengthening primary care and retention.[44]

The government has also published a 10-Year Capital Plan for Health and Social Care and has committed up to £10bn for NHS technology and digital transformation by 2028/29.[45] This is close to estimates published by the Health Foundation about what it would take to digitise the NHS, but this research also highlighted the importance of balancing capital investment with support for implementation and training.[46]

However, translating these ambitions into sustained productivity gains will be difficult. Successive NHS strategies have sought to strengthen prevention, expand care outside hospital and make greater use of technology, but progress has been slow and uneven.[46,47] Nor should it be assumed that such reforms automatically improve productivity: their impact will depend on how they are implemented and whether they ultimately improve outcomes and value.[47,48,49]

The next section examines the barriers that have repeatedly prevented the NHS from achieving sustained productivity growth.

Barriers to higher productivity

> ‘The friction ends up in the middle… [middle management] has to listen to the leaders, try to translate that vision into practical implementation, but also listen to the people actually out there on the ground doing the work.’
>
> Bart van Ark, Professor, The Productivity Institute, University of Manchester (evidence event)

To understand how the barriers to improving productivity emerge, we examine them across each of our productivity drivers: workforce, capital, technology and innovation, and transformation. The policy options papers published alongside this report explore each area in further detail.

How barriers emerge across each productivity driver

Workforce

The NHS depends on staff to identify waste and improve services but too often gives them little time, support or authority to do so. Strong management, leadership and staff trust and engagement are associated with better organisational performance.[50] But there is evidence that the NHS is undermanaged and that management capability varies across organisations.[51,52]

We also heard that a culture of blame inhibits learning and innovation and that the implicit social contract between the NHS and its workforce shows clear signs of fracture. Around 30% of staff often think about leaving their organisation while less than half (49%) feel meaningfully involved in decisions affecting their work.[53] Burnout, absences and weaknesses in basic workplace factors, such as team stability, line management and onboarding, further undermine productivity.[44]

Although research is limited, evidence suggests staff turnover is linked to poorer organisational performance and reduced efficiency.[54] Overall leaver rates have improved since their post-pandemic peak, but many NHS staff continue to move between organisations, and the number of staff leaving for work-life balance and health reasons roughly quadrupled in the decade up to 2022.[55] Low retention is a particular challenge in general practice. Between 2015 and 2024, the NHS lost one full-time equivalent GP each year for every five additional licensed GPs.[27]

Changing health needs, new models of care such as neighbourhood health, greater role diversification within multidisciplinary teams and rapid technological change are reshaping workforce requirements. Despite this, workforce policies, role boundaries, education pipelines and HR systems remain better aligned to existing roles than enabling, designing and evaluating new ways of working.

Capital

Capital is a fundamental driver of productivity, yet the UK invested less in health care capital than peer countries in the 2010s.[56,57] The effects are visible across the system. The maintenance backlog – the bill for essential repairs – is large and growing.[58] Ageing hospital buildings and constrained diagnostic, theatre and bed capacity make reliable flow through the system harder to achieve. Many general practice, mental health and community premises are not fit for purpose.[59]

The problem is not only the level of capital investment, but the way capital is allocated and managed. Funding is often fragmented, short term and tightly controlled, with multiple pots, late allocations and rules that favour investments that can be delivered quickly or meet central criteria over those that would deliver greatest long-term value. Difficulty transferring assets between NHS organisations, partly because of unclear rules, adds further friction.

Combined with weak prioritisation, limited implementation support and insufficient focus on realising the benefits, this leaves the NHS with underused assets, delayed schemes and infrastructure that is too slow to adapt to changes in how care needs to be delivered.

Technology and innovation

Technology and innovation offer significant opportunities for the NHS to improve productivity. With the right guardrails in place, AI in particular could transform ways of working, through reducing the administrative burden, supporting clinical decision making, strengthening patient self-management and augmenting population health management.[60]

Yet the NHS has repeatedly struggled to take advantage of the potential offered by technology. This includes even well-established technologies, with recent polling by the Health Foundation finding more than a third of NHS staff said that electronic patient records (EPRs) are not currently working well in their organisation.[61] Weak digital infrastructure, patchy data standards, uneven skills across the workforce and variable capabilities around benefits realisation all undermine change.

The NHS does not consistently identify priority problems, shape markets, test new technologies and evaluate their real-world effects on outcomes, workflows and staff experience. While there are pockets of good practice, these underlying conditions inhibit the effective testing, implementation, scale and spread of both proven and promising technologies.

Transformation

Productivity depends not only on running services better, but on shifting resources and redesigning care. Primary, community and preventive care can offer better value for some patients and pathways, yet NHS resources remain concentrated in hospitals.[62,63] In the 2010s, GP appointments failed to keep pace with population change, while outpatient activity grew far faster.[64,65]

Part of the reason is that the rules and incentives are clearer in acute care. Hospital activity is more consistently counted, costed and paid for, while data and outcome measures are weaker in community and mental health services in particular. Different payment models can support different productivity goals, but each can also reinforce the wrong pattern of care or fall short of expectations if poorly designed or implemented.[66,67,68]

The bigger problem is that the NHS lacks stable ways to shift resources across whole pathways. Commissioning is meant to perform this role but has struggled to deliver across different contexts.[69] In the NHS, repeated restructuring, shifting responsibilities and short-term financial pressures have made it harder still to take consistent system-wide decisions about where resources should move.[70]

Even within existing services, leaders are pulled between many competing targets, asks and recovery priorities, leaving little space to redesign care or identify longer term bottlenecks that need addressing.

A self-perpetuating cycle

Although different productivity opportunities encounter different immediate barriers, our evidence also points to a common set of conditions that make all of them harder to overcome. These are: short-term planning, fragmented accountability, excessive regulatory and assurance burdens, and insufficient managerial, analytical, digital, commercial and operational capability.

So, why have these barriers emerged? Persistent financial and performance pressures, political volatility, repeated reorganisations and high-profile failures in care (including recent maternity and other patient safety scandals) have understandably prompted new targets, reviews, standards and controls. At the same time, expanding visible front-line roles is often politically easier to defend than investing in management and enabling functions. Cuts to 'administration' can appear politically attractive, even when they weaken the capacity to organise care, support clinical staff and deliver change.

These pressures reinforce one another and undermine productivity. Performance or financial pressures can result in new requirements or targets that consume scarce leadership or improvement capability, further weakening performance and prompting scrutiny, intervention and control. The result is a self-perpetuating cycle of short-term planning, priority overload, growing compliance burdens and insufficient capacity for improvement.

The current context risks reinforcing these dynamics. The NHS is under pressure to recover access and waiting times performance, while also operating within a constrained financial settlement and undergoing major organisational change, including the abolition of NHS England. Longer term projections vary but all point to sustained pressure on health spending. Faced with these demands, it is understandable that attention gravitates towards short-term performance, tighter oversight and visible delivery. Yet these are the same conditions that have historically encouraged the accumulation of priorities, controls and reporting requirements, often at the expense of creating the capability and headroom needed for sustained productivity improvement.

If the NHS is to deliver meaningful productivity gains, it must break this cycle. The next section sets out four conditions needed to do that.

Four conditions for improved productivity

> ‘It’s not just about leadership and management in the conventional terms, it’s about creating the conditions for change to happen.’
>
> Charlie Mayfield, Co-chair, Keep Britain Working (evidence event)

Our work points to common problems across the four drivers of productivity, reflecting fundamental challenges in the broader way the NHS is overseen and managed.

This section sets out four conditions for changing that environment (Figure 6), which are needed to effect lasting change in a complex system like the NHS. For each condition, we describe how the current system constrains improving productivity before articulating an alternative vision. We identify key recommendations to help realise that vision, summarised at the end of this section. As the recommendations are system-level, they are largely aimed at DHSC (which we assume will absorb the functions of NHS England, in line with current legislative plans).

The conditions for productivity improvement we describe here should actively support the direction of national policy and complement, rather than replace, local improvement, clinical judgement and professional leadership. Importantly, they should not be layered on top of ‘business as usual’ and become yet another set of new initiatives. As we highlight, many require reducing activity and complexity to give the system the headroom to focus on improving productivity.

These four conditions reinforce one another and need to be pursued in tandem. Importantly, the conditions should be developed with patients and staff, rather than imposed on them.

Figure 6: Four core conditions for creating productivity growth in the NHS

From		To
Constant churn	→	Stable direction
Priority overload	→	Focused accountability
Excessive compliance	→	Freedom to deliver
Episodic change	→	Capability to improve

From constant churn...

Instability has become a defining feature of the NHS in recent decades. Respondents to our call for evidence described the disruptive effects of short-term policy cycles, annual planning rounds, non-recurrent funding pots and repeated restructuring.

Improving productivity and allocating resources more effectively will require changes that take longer than a single financial year to deliver.[71] Yet the NHS expects leaders to deliver long-term changes while operating through short-term budgets, shifting priorities and late funding decisions. The system therefore naturally favours what can be approved, spent and counted quickly over what would create greater long-term value.

In part, this reflects legitimate pressures on governments and national bodies to improve performance quickly, respond to emerging problems and demonstrate accountability for public spending. But while understandable, collectively these responses can undermine the organisational stability that productivity growth requires.

The abolition of NHS England is the latest major change to national architecture.[72,73] NHS reorganisations have repeatedly been associated with disruption, uncertainty, lower staff morale and leadership churn.[74] No part of the NHS has experienced this instability more consistently than commissioning, despite being expected to make long-term choices about resource allocation and service configuration.[70] Political churn has contributed to this instability, with around 50 people having served as ministers in DHSC since 2015.[75]

Financial instability has also become a persistent feature. Plans are frequently revised during the year or brought into balance through non-recurrent support and other temporary measures, weakening longer term planning.[76] More recently, inflation and industrial action have added costs and disrupted activity, making it harder for providers to deliver.

High performance in health care and other sectors relies on clear, durable goals.[77] The benefits of stability have been repeatedly highlighted in research – including on the association between consistent strategies and improvements in cancer survival, for example – as well as in our evidence sessions.[78,79,80]

... To stable direction

The NHS needs a clearer, more stable direction. Stability allows better targeting of resources for value for money. It enables system leaders and decision makers to invest in changes even where realising the benefits takes time: estate modernisation, strengthening digital foundations, workforce redesign and new care models.

Predictable funding would allow providers to plan the opening, expansion and closure of services and assets needed to realise productivity gains. Longer term funding signals would also give NHS suppliers greater confidence to invest and build capacity.

National policies and planning for workforce, capital and technology will need to be aligned and underpinned by shared assumptions about care that are transparent, informed by multidisciplinary (clinical and operational) expertise and revised as more evidence emerges. This approach could build on existing good practice in transparent modelling of demand and capacity for the New Hospitals Programme.[81]

Aligned planning could also set clearer expectations about the scale and direction of change. Plans should give local leaders enough clarity to plan, invest and make decisions, without becoming a mandatory blueprint for every pathway or workflow.

New payment mechanisms or new structures will only support change when matched to clear objectives, aligned across the system and backed by the required capabilities.[82,83] Misaligned payment systems across the NHS can run counter to the intended model of care, while frequent changes to tariff structures can see time for care lost to negotiating payments.[84,85]

This is pertinent to new IHO contracts. Similar models in the US have improved performance, but success has depended on strong underpinning digital infrastructure, data and leadership.[86,87] The lesson is to adopt these models selectively and build the necessary foundations first. Adoption should depend on local maturity, with support for contracting, safeguards and implementation from the centre.

Making it happen

1. Establish a 5-year planning and investment framework

The Treasury and DHSC should establish a stable, multi-year planning and investment framework to support long-term productivity growth.

At the 2027 Spending Review, the Treasury and DHSC should establish a rolling 5-year planning and investment framework, with firm funding and planning assumptions for the first 3 years and indicative assumptions for the following 2 years. This builds on the move towards longer term capital and revenue funding, but the assumptions should be cascaded to systems and providers so that they have long-term clarity on finances. Progress should be reviewed against agreed plans, with expected benefits and credible delivery trajectories.

This framework should go further than outlining the budgets. Alongside this, DHSC should:

- align revenue, capital, workforce, digital investment and payment policy around a transparent set of planning assumptions (in line with the priorities of the 10-Year Health Plan)
- replace fragmented short-term funding pots, initiatives and overlapping planning requirements with a coherent multi-year approach
- give systems and providers sufficient flexibility to combine resources and meet the transition costs of service change, including further freedoms over spending (eg to shift from revenue to capital, or from acute to prevention or adult social care) and greater provider flexibility over capital
- provide stable policy and payment assumptions, allowing for revision where new evidence emerges, that should include a plan to improve data quality and move away from block payments in non-acute settings.

Together, these changes would give greater clarity over funding and more flexibility to use it well. This would move the NHS closer to the principle that a 'pound is a pound', with fewer rules and short-term pots dictating how resources are used. This would give local leaders greater confidence to make long-term decisions while maintaining national discipline over resources.

2. Refrain from further major reorganisation

Government should quickly settle the outstanding structural organisational issues relating to the Health Bill and devolution, and then refrain from further major reorganisation.

Beyond outstanding reforms in the Health Bill and issues like devolution and integrated care system boundaries, which government should settle as quickly as possible, this government and subsequent governments should keep major structural change to a minimum. Many desired changes and policy reforms can be pursued iteratively, without the upheaval of legislative and structural change.

> '[There] has to be a clear development plan that systematically builds on what has been done before.'
>
> Ellen Nolte, Professor of Health Services and Systems Research, LSHTM (evidence event)

From priority overload...

When goals are unclear, too numerous or competing, choices become harder to make. Productivity growth requires focused attention, resources and effort on the changes most likely to improve outcomes and value.

The NHS constitution sets out its core principles and values, while the statutory triple aim requires NHS bodies to consider impacts on population health and wellbeing, the quality of services and sustainable use of resources. But these are not consistently used to organise priorities and drive improvement.

By contrast, NHS leaders are subject to a high number of targets and metrics. The 2026/27 NHS Oversight Framework has already grown to 86 metrics, with 24 added this year alone.[88] Even after recent simplification efforts, there are still 43 indicators in the Quality and Outcomes Framework for general practice. Many of these measures matter, but their cumulative effect can blur and fragment priorities, leaving less scope for local leaders to focus efforts where they can have greatest impact.

Targets can improve performance, as in the 2000s when a small number of national priorities helped to reduce long waits.[89,90] But as Goodhart's law suggests, they can also narrow attention, pushing organisations to act on what is measured at the expense of patients.[91] This is also relevant in general practice, where a focus on access can come into tension with continuity of care.[92,93]

The NHS in England is also highly centralised. Evidence on decentralisation in health care is mixed.[94,95,96,97,98] Greater local autonomy can support adaptation, ownership and faster decision making, but excessive decentralisation can also create fragmentation. The critical question is not whether the NHS should be centralised or decentralised, but how different tasks and decisions are best taken nationally, regionally and locally.[73,99]

The result is a highly controlled but insufficiently accountable system. Local leaders face extensive oversight yet have limited freedom to improve outcomes across pathways. Productivity depends on decisions made across organisational boundaries and over the longer term. Accountability should therefore be clearer, better aligned with decision rights and more focused on outcomes and value.

... To focused accountability

A more productive NHS needs a shared purpose and clearer sense of accountability. This should be backed by a small number of stable national goals, clear minimum standards and locally owned priorities.

The number of metrics in the NHS Oversight Framework should be reduced to focus on a disciplined set of core minimum standards, although staff engagement should remain prominent given its importance as a leading indicator for productivity and outcomes.[50]

Minimum standards are essential in the NHS, but they should be realistic, mutually consistent and designed with longer term productivity improvement in mind. The periodic review of the rights and pledges within the NHS constitution could help ensure that standards remain achievable and support productivity.

Local leaders are best placed to understand population needs, redesign pathways and align resources across services, as recognised in recent policy announcements on devolution.[97,98,100] Local systems should translate national goals into a small number of priorities based on population needs and opportunities to improve outcomes and value.

Accountability should be matched by capability, with greater local freedom over resources, including over capital spend. Some critical constraints on NHS performance lie outside the health service, but stronger local political buy-in could help to align resources with priorities.[101] The Modern Productive Series exemplifies a movement focused on locally led productivity improvement in the NHS.[102]

Greater local decision making must be accompanied by transparency.[103] Comparative data should support learning, peer challenge and mutual accountability, rather than operate as a public league table. NHS regions should support benchmarking, learning, cross-boundary planning and organisations that are off track.

Over time, the balance of measurement, reporting and contracting should shift towards outcomes, patient experience and value. The OECD Patient-Reported Indicator Survey provides a useful model of more holistic measures of quality.[104] Outcomes metrics should be used alongside timely tracer measures along pathways, such as detection, access and survival.

Making it happen

3. Set a clear purpose on productivity

DHSC should set a clear productivity-focused purpose: achieving better outcomes within the resources available. This should be backed by a small number of national goals and clear minimum standards.

The secretary of state and DHSC should set a clear 'north star' for the health system, backed by a small number of national goals, rebalanced towards primary, community and mental health care. The north star should build on the existing triple aim, while making its implications for productivity explicit: improving outcomes, the quality of care and reducing inequalities within the resources available.

The centre should also set clear minimum standards including for finance and NHS constitutional standards. The oversight framework should be trimmed back, and standards need to be set at a level that is credible and patients can expect providers to meet. Alongside CQC assessments, which should explicitly incorporate staff engagement scores from the NHS staff survey, these minimum standards should help determine when national intervention is needed. Intensive intervention should be reserved for significant or persistent failure.

4. Devolve more authority and accountability for improving productivity

The NHS should devolve greater authority and accountability for improving services and productivity to local systems.

Each integrated care board should identify three to five priorities for its population, focusing on the pathways or groups of patients where action could have the greatest impact. Local plans should set out these priorities, how progress will be assessed and the contribution expected of each organisation. They should be jointly signed off by the NHS region and, where they exist, the relevant mayoral or strategic authority.

Providers across the NHS should be given substantially more freedom as a default to meet these priorities and standards, including over capital

spending. NHS regions should support benchmarking, peer challenge and shared learning, while acting as the first point of support and assurance when organisations or systems are off track, rather than acting as another layer of oversight. They should also coordinate cross-cutting issues, including shared infrastructure, large capital investments, cross-boundary services, workforce planning and market-shaping. Over time regions should be able to articulate common regional challenges through joint problem books.

Continuity is critical. This Commission believes the Health Bill should place a duty on the secretary of state to maintain regional NHS arrangements across England. There is a case for going further on devolution, but wider change should be pursued where it strengthens accountability, improves value for money and is compatible with the founding principles of the NHS.

5. Expand outcomes measurement

DHSC should extend and improve outcomes measurement so that performance can be better assessed across the NHS.

The NHS should collect more national patient-reported outcomes (PROMs) and experience measures (PREMs), with greater weight given to these in national and local goals. Systems, providers, staff and boards should be able to make greater use of these data to guide improvement and resource allocation.

Data need to be comprehensive and high quality. DHSC should set standards to assure the quality of the data and support its consistent interpretation and use. Patients should be able to report outcomes and experiences through the NHS App, as well as other non-digital routes. Reporting needs to be transparent so the public can understand performance. The NHS in England should also join the OECD Patient-Reported Indicator Survey (PaRIS) programme.

> ‘I am the accountable officer for the care that’s provided by the organisation. I need to assure delivery to the trust board in public, not just to the centre.’
>
> James Benson, Chief Executive, Central London Community Healthcare NHS Trust (evidence event)

From excessive compliance...

When goals are unclear and risks highly visible, the system often responds by adding more controls and assurance. Each may have its rationale, but together they create 'priority thickets', leaving it unclear what is most important.[105]

To improve care or respond to serious failures, new guidance or regulation can be the obvious lever to pull. It may even appear 'free' when, in fact, it absorbs time and energy across the system. Across the call for evidence, we heard a common concern that the NHS has become increasingly compliance and assurance driven in a way that is becoming burdensome and overbearing.

Wider evidence from health care supports this. For instance, analysis of a simple surgical pathway found the number of steps had risen from 46 to 265 over 20 years.[106] The Health Services Safety Investigations Body (HSSIB) also highlighted the scale and complexity of health care recommendations, with research identifying more than 126 organisations with regulatory influence over NHS providers.[107]

Accumulating regulations, guidance and assurance do not necessarily make care safer. The Berwick Review argued that safer care depends on openness, learning and improvement, not fear and excessive regulation.[108] The Dash Review similarly emphasised clear, focused and proportionate oversight.[109] By contrast, layers of bureaucracy have been linked to lower levels of innovation and staff wellbeing, hindering improvement.[110]

This 'compliance culture' can create hesitancy around new models of care and act as a drag on productivity and a barrier to innovation. Redesigning roles and pathways is crucial to harnessing the benefits of skill mix changes and new technologies. We heard evidence that AI is likely to reshape a substantial share of health care work, but this is mainly by augmenting rather than replacing existing roles.[111]

Yet we heard that the NHS has a tendency to scrutinise the risks of change more closely than the consequences of maintaining the status quo. Whether at the centre or locally, scarce leadership and staff time is being spent interpreting requirements and managing assurance, rather than improving flow, simplifying pathways and supporting staff to change how work is done.[112]

... To freedom to deliver

A more productive NHS would be simpler to work in and easier to improve. 'Have we complied with the rules?' would shift to 'Have we done the best for patients and the public?' We heard the latter conditions led to a faster pace of change during COVID-19.

National bodies should measure the cumulative volume and complexity of what they ask the NHS to absorb. Requirements should be judged by the value they create relative to the burden they impose. The question should be not only whether a requirement improves care or a particular process, but whether it is more effective and proportionate. New requirements should focus on outcomes and be clear to understand and act on.

Tackling this problem requires a dedicated mechanism rather than another time-limited initiative. The Office for Tax Simplification offers one precedent outside of health care.[113] Within health, the Department of Health operated an 'external gateway' from the early 2000s, which challenged new requirements, targets, plans and data collections before they were issued. More recently, DHSC's Busting Bureaucracy sought to identify and remove unnecessary burdens on a time-limited basis.[114] A permanent function could go further: reducing the existing stock of requirements while challenging new ones before they reach the service.

When it comes to driving innovation, the emphasis should be on generating robust, transparent evidence rather than encouraging adoption before it exists. Good practice in rapid evaluation and simulation exists, but capability is unevenly distributed.[115] The aim should not be to create more isolated pilots, but clear routes for experimentation, supporting local teams to test and adapt new approaches with robust evaluation. Time-limited freedoms applied in the Netherlands offer one example.[116] The pace of change with some technologies, particularly AI, reinforces this need for robust rapid evaluation.[117]

The NHS's funding model and national data assets should make it one of the world's leading environments for real-world evaluation. National bodies should therefore play a stronger role in coordinating experimentation, generating evidence and supporting adoption. The focus should be on creating a faster route from innovation to routine practice, recognising that scale economies are critical to productivity growth.[118]

Making it happen

6. Reduce the burden of rules and controls

DHSC should systematically reduce requirements that divert time and capacity from improving care, with a dedicated unit established to drive change.

DHSC should systematically identify and remove unnecessary, duplicative or disproportionate requirements across legislation, regulation, guidance, financial controls and assurance processes. Where responsibilities are fragmented, it should consolidate them where practicable or establish a single point of accountability. Requirements should focus on outcomes rather than processes, have a named owner and be subject to sunset or mandatory review clauses.

To give this momentum, the Commission believes DHSC should establish a dedicated unit, an 'office for NHS simplification', with an independent chair, backed by the secretary of state and with the authority to challenge requirements created across national bodies. Working with regulators, arm's-length bodies and professional bodies, it should maintain a rolling programme to identify duplicative, obsolete, disproportionate or poorly designed requirements. It should publish evidence of the burden removed. It should also provide a gateway for significant new requirements, compelling national bodies to demonstrate their necessity, proportionality and likely burden before they are introduced.

One of the office's first programmes should review capital approval routes, building on recent reforms to identify remaining duplication between business case stage and approval, and simplify ownership and transfer arrangements that prevent effective use of the NHS estate.

7. Create a 'test-and-learn' approach

DHSC should create a rapid national 'test-and-learn' approach to identify, evaluate and scale more productive models of care and emerging technologies.

DHSC should establish this approach so that providers and systems can test new workforce and service models, pathway redesigns and

emerging technologies where the effects, risks or regulatory implications are uncertain. It should coordinate national bodies, regulators and commissioners and remove avoidable regulatory, contractual and payment barriers.

Testing should be proportional to the innovation. Rapidly evolving or higher risk applications of AI may require controlled testing, followed by validation in a small number of representative early-adopter sites. Service, pathway and workforce changes should generally be tested across a broader range of NHS settings, provided they are co-designed, implemented and evaluated with the support and active involvement of relevant staff and clinical leadership. Where appropriate, the route should allow time-limited regulatory or professional flexibilities to test new roles, team configurations and scopes of practice under controlled conditions.

A coordinated evaluation function should bring together national bodies and participating providers, agree common measures and support credible multi-site evaluation. Testing should use staged decisions about whether to continue, adapt or stop. Findings, including failures, should be published promptly and transparently, and evidence generated in one part of the NHS should inform decisions and adoption elsewhere through coordinated learning networks.

> ‘Productivity is all about liberating skills and talents and bringing joy into work.’
>
> Mark Britnell, Chair, Health Innovation Manchester (evidence event)

From episodic change...

Even when teams can see what needs to change, they require the capability to make that change happen. We repeatedly heard that staff and organisations could see the problem, but lacked the skills, capacity and infrastructure to respond. This capability gap covers both technical disciplines – such as operational management – and the people skills needed to lead cultural and behavioural change.

Digital capability was a recurring concern. While technology is widely seen as a major opportunity for improving productivity, benefits are limited by weak implementation capability, inconsistent digital skills and fragmented systems.[119,120] Staff often have to duplicate work, manually transfer information or work around poor interoperability.[120] The OECD reports that enabling health data interoperability could be worth between 2.7% to 6.6% of health system expenditure.[121] As advanced technologies become ever more central to care delivery, these constraints become increasingly costly.

Management capacity is another important constraint. Research consistently links stronger management with better efficiency, quality and patient experience.[122] Yet it is not uncommon in the NHS for senior clinical leaders to have responsibility for very large numbers of staff with little protected time for management or improvement. At the same time, limited discretion over how resources are deployed or services are organised can reduce managers' ability to improve performance.[123]

The management of patient flow illustrates why these capabilities matter. Improving flow depends on understanding: forecasting demand, matching capacity, identifying bottlenecks, coordinating teams and acting quickly when constraints emerge. These are operational disciplines. Without them, organisations can default to adding staff, beds, targets or initiatives, even when better scheduling, process redesign or coordination would deliver more value.

The result is that the NHS often knows what needs to improve but struggles to implement and spread solutions. Promising ideas can remain local, with the benefits not fully realised and similar problems repeatedly solved from scratch.

... To capability to improve

A more productive NHS would treat the capability to change as part of its core infrastructure. This requires a shift in how the NHS invests in and supports management and other non-front-line skills and capabilities.

Leadership and management capacity needs to be strengthened close to front-line teams and planned as seriously as the clinical workforce. Leaders and managers need the time, information, judgement, skills and authority to understand services, manage flow and capacity, support teams, use data and act on opportunities to improve.

Training is part of the answer. The new NHS College of Leadership and Management could equip leaders with the skills and behaviours needed to drive improved productivity. But capability is also developed through exposure to organisations tackling similar problems. The NHS needs a stronger learning health system approach, investing more systematically in relationships, networks and infrastructure.[124]

There is also a case for pooling scarce or specialist capability where approaches can be standardised or expertise is difficult to sustain locally. Skills worth sharing include: advanced analytics, digital implementation, data architecture, evaluation, commercial, benefits realisation and pathway redesign. Major capital schemes illustrate the point: individual trusts may deliver only one in a generation, while regions repeatedly build expertise lost between programmes.

The early successes of the NHS Modernisation Agency show the potential of this approach when kept focused.[125] Further, examples from other health systems, for instance from Norway, show how the right support offer can sustain and share expertise.[126,127] Research suggests the NHS currently fails to maximise the value of such capability offers.[128]

Some support or infrastructure should be built once at the centre, especially digital foundations. But, as the NHS reorganises around seven regions, support should be aligned and strengthened at regional level. Regions are large enough to sustain specialist capability, but small enough for organisations to learn from one another. Providers, integrated care boards and regional directors should decide how best to organise this locally. But the emphasis should be on provider-led improvement, supported by stronger peer networks, shared capability and collaborative learning.

Making it happen

8. Recognise and invest in the non-clinical workforce

DHSC should develop and implement a workforce plan for the leadership, management and improvement capability needed to support productivity growth.

As we await the forthcoming workforce plan, policymakers should consider how the next iteration will recognise the importance of non-clinical staff to NHS productivity, including HR, analytical and operational roles, and rebuild graduate, clinical leadership and senior talent pipelines. The plan needs to set out a coherent approach to the scale and composition of the non-clinical workforce required to run the health system effectively. Much management and leadership is carried out by clinical staff leading teams and services. The NHS workforce plan needs to ensure that clinical staff have the time and development opportunities to be effective managers and leaders, in addition to their other roles and responsibilities.

The plan should also place greater focus on the capabilities required to improve productivity. In addition to traditional leadership and management skills, education, training and professional development, the plan should emphasise improvement science, service redesign, demand and capacity management, use of data, and identifying and reducing clinical and operational waste. This approach should be strengthened by the new NHS College of Leadership and Management also focusing on these skills and areas of expertise.

9. Pool expertise and strengthen knowledge sharing

Providers should pool and draw on scarce expertise across their region to support productivity improvement.

Regions should invest in a shared capability offer that providers can draw on when needed, including expertise in analytics, procurement, evaluation, digital implementation, operational improvement, capital delivery and benefits realisation. DHSC should remove arbitrary national caps on staff working in such roles.

This capability should support priorities identified locally and initially focus on a small number of clearly defined problems that sharing provider expertise could potentially help to solve – for example, realising the benefits of electronic patient records or improving hospital flow.

Regions should convene and fund the model, drawing existing expertise together and commissioning additional support as needed. They should also recognise and share successes and learning. Providers should retain responsibility for identifying priorities, leading delivery and achieving outcomes. Regional support should be judged by whether it helps providers deliver measurable and sustained improvements in productivity.

10. Build interoperable digital infrastructure

DHSC should strengthen data standards and mandate interoperability.

To deliver more joined-up care and to lay the groundwork for more ambitious digital and service transformation, the NHS needs to improve its data standards and the ability of systems to speak to one another. This requires concerted direction from the centre.

Building on previous plans, DHSC should now publish a practical interoperability roadmap aligned with the Single Patient Record (SPR) programme. This should confirm the government's commitment to prioritise information sharing in specific care pathways (ie maternity and frailty, those areas already earmarked by the SPR). The roadmap should further set out which common standards NHS organisations and technology suppliers must adopt, when they must adopt them, who is responsible for delivery, how compliance will be tested and enforced, and how implementation will be funded and supported.

Using powers strengthened by the Data (Use and Access) Act 2025, relevant standards should be binding on NHS organisations and technology suppliers. NHS providers should also have access to pooled commercial and technical expertise (see recommendation 9), enabling them to negotiate effectively with suppliers and implement the standards.

Summary of recommendations

Implementing these recommendations would allow the NHS to start realising a more stable, focused, free and capable system.

Stable direction

- The Treasury and DHSC should establish a stable, multi-year planning and investment framework to support long-term productivity growth.
- Government should quickly settle the outstanding structural organisational issues relating to the Health Bill and devolution, and then refrain from further major reorganisation.

Focused accountability

- DHSC should set a clear productivity-focused purpose: achieving better outcomes within the resources available. This should be backed by a small number of national goals and clear minimum standards.
- The NHS should devolve greater authority and accountability for improving services and productivity to local systems.
- DHSC should extend and improve outcomes measurement so that performance can be better assessed across the NHS.

Freedom to deliver

- DHSC should systematically reduce requirements that divert time and capacity from improving care, with a dedicated unit established to drive change.
- DHSC should create a rapid national 'test-and-learn' approach to identify, evaluate and scale more productive models of care and emerging technologies.

Capability to improve

- DHSC should develop and implement a workforce plan for the leadership, management and improvement capability needed to support productivity growth.
- Providers should pool and draw on scarce expertise across their region to support productivity improvement.
- DHSC should strengthen data standards and mandate interoperability.

What would change?

Taken together, the four conditions for improving productivity would translate into a different approach to running the NHS. This would create stronger conditions for sustained productivity growth but also involve trade-offs.

This section looks at examples of what would change under our recommendations. We then share two test examples for assessing impact.

Table 2: What would change under our recommendations?

Level	Focus on...	Avoid...
National (DHSC)	**Clear expectations, stable direction and common foundations** • Set few, clear priorities, backed by firm guardrails. • Transparent medium-term planning and strategic investments. • Build outcomes infrastructure, common data standards, evaluation frameworks, model contracts and reusable tools.	**National improvement to-do lists** • Less detailed guidance and control over local process. • Fewer short-term funding pots and fewer one-off waiting list initiatives.
NHS regions	**Coordinate, support and build capability** • Review progress against local plans. • Provide benchmarking, peer challenge and diagnostic support. • Coordinate cross-boundary issues and deploy scarce expertise where it adds value.	**Duplicating national assurance** • Less passing returns upwards, rechecking core guardrails or micromanaging providers.
Systems/ICBs/ local areas	**Align resources around population need and pathway value** • Set small number of local priorities. • Align budgets, incentives and contracts and make trade-offs explicit.	**Low-value transactions** • Less routine contract dispute resolution, adversarial challenge and activity-focused process management.
Providers/ leaders	**Improve care in practice** • Redesign pathways with staff and patients. • Improve quality, flow, staffing, administration and experience.	**Local reinvention and silo optimisation** • Less time spent reporting upwards, repeating pilots or solving common problems alone.
Staff, patients and the public	**Shape what matters and how care improves** • Patient outcomes and experience shape priorities. • Staff engagement is taken seriously, while staff meaningfully inform design.	**Tokenistic involvement** • Less consultation after decisions are made or asking staff to absorb changes imposed from above.

Roles and responsibilities

The approach set out is not principally about moving responsibility up or down the system. It is about being clearer about what each layer of the NHS is best placed to do – and what it should do less of (Table 2).

The key question is, where are the different functions best performed? What should be provided once for the whole NHS, what should be shaped around populations and pathways, and where do teams need the freedom to test, learn and improve?[99]

This distinction is especially important in the context of NHS reorganisation and the transfer of functions from NHS England to DHSC as part of the Health Bill.[129] Greater national control could increase instability and short-term intervention, unless matched by discipline about what the centre should and should not do.

Box 4: Workforce: stronger teams, more engaged staff

Workforce policy would shift from seeing productivity primarily as a question of staffing numbers and activity, towards something delivered by people who are aligned around a shared purpose. The NHS would place greater emphasis on staff engagement as a leading indicator of productivity. Workforce planning would prioritise retention, high-quality leadership, management and team effectiveness as drivers of productivity. It would recognise improving productivity depends on the motivation, judgement and agency of front-line staff.

The underlying goal is to rebuild the social contract between the NHS and its workforce, moving away from a model based on pressure, compliance and intensifying workloads towards one based on support, trust and continuous improvement.

Under these conditions, productivity comes not from working staff harder and harder, but from enabling them to work differently: in better designed teams, with stronger leadership, clearer opportunities and shared purpose to improve care, alongside workforce planning co-designed with staff and more closely aligned to the future needs of patients and services.

This operating model also depends on being clearer about the capabilities each layer needs. Providers need stronger management, operational and analytical capability close to care delivery. Systems need the ability to understand population need, pathways and outcomes. At regional level, there needs to be pooled capability for what cannot be housed or distributed across organisations. The centre needs to provide the common enablers that should not be rebuilt locally: outcomes infrastructure, data standards, evaluation frameworks, model contracts, specialist procurement support and contractual routes for new models of care.

Box 5: Capital: a simpler, more stable system

Capital planning should begin with the model of care the NHS is trying to create, rather than simply maintaining or replacing its existing estate. The centre should set a long-term capital strategy showing how investment will support the planned balance between hospital, neighbourhood, primary and community care. A dedicated primary care estates strategy is needed so that ambitions to move care closer to home are matched by suitable buildings, diagnostics and digital infrastructure.

Providers should receive firm multi-year capital envelopes and greater freedom to carry funding forward and move revenue into capital where fiscal rules allow. Capital decision making should be devolved as far as possible: providers should make routine investment decisions, systems and regions should coordinate strategic service transformation and cross-provider investments, and the centre should focus on major national programmes and setting the overall framework. Legal and financial barriers that prevent NHS land and buildings being transferred or repurposed should be removed.

Regional major development units and transformation teams should retain specialist expertise in design, commercial delivery and benefits realisation. Their role should be to help providers deliver complex investments and ensure that new buildings, equipment and technology translate into better care and higher productivity.

Trade-offs

The approach set out in the report involves genuine trade-offs. First, the centre would have to give up some direct control over how improving productivity happens, where money is spent and what is prioritised. Regions, systems and providers should have more room to choose different methods, sequence changes differently and adapt models to local context, while operating within minimum standards.

This may entail further trade-offs between short-term and longer term performance. A system with less control will need to tolerate some increase in variation over the short term. There will also be some failures. But we repeatedly heard that productive organisations are willing to experiment and learn from failure.[80] This is hard to do when accountability can be very public. But it would be a price worth paying were it to allow the NHS to learn and ultimately improve faster.

NHS provider organisations too, while gaining some freedoms, should face stronger expectations to use data, learn from peers, share what works and improve over time. Failed tests should be accepted or tolerated, but repeated failure to learn should not.

Another major trade-off is that a larger share of future investment will almost certainly need to go into the inputs that support existing front-line staff to be more productive, and less into creating additional front-line posts. We are not dictating what the 'right' level should be; organisations need to identify their own bottlenecks and act accordingly.

But productivity growth requires a different mix of resources: a step change in investment in capital, as well as analytical, operational and digital capability. The alternative, continuing with the same broad pattern of investment prioritising front-line staff, would only mean more of the same.

Box 6: Technology and innovation: building shared infrastructure

DHSC and the regions have an important role to play in strengthening the underlying digital infrastructure of the NHS. The centre should provide the shared platforms and common infrastructure needed across the NHS, where duplication is unnecessary or undesirable. This includes delivery of current commitments around the NHS App, NHS Online and single patient record, as well as regulation of AI.

The centre should also play a stronger role in procuring technology. With products in common usage – like ambient voice technology, for example – it should identify, test and validate a shortlist of products or suppliers, negotiating and securing a good price. NHS provider organisations would then be able to choose what best meets their needs from this shortlist without needing to repeat processes around information governance and procurement.

Regions would have an important role to play in signalling demand, sharing learning, and scaling what works across their footprint. Examples of strong regional ownership of common digital infrastructure include the shared EPR system and patient portal across Devon or the work in Greater Manchester and South Yorkshire on shared care records.[130,131,132]

Box 7: Transformation: aligning financial incentives

The NHS would move from a system characterised by short-term planning, fragmented incentives, extensive central oversight and limited improvement capacity towards one with greater stability, clearer accountability and stronger local capability to improve services.

A central part of this shift is ensuring that incentives support, rather than obstruct, change. Payment systems, performance frameworks and accountability arrangements would be better aligned with the outcomes the NHS is trying to achieve, reducing the tendency for organisations to optimise individual institutions rather than whole pathways of care. Providers and systems would have greater certainty about how they are paid, supported by a longer term payment strategy and more stable financial architecture.

This would require a stronger data and measurement infrastructure, particularly in community, mental health and primary care services. Improved data, costing and outcomes measurement would support payment approaches better suited to these sectors, while enabling a greater use of best-practice, pathway-based and outcomes-focused payment models. The aim is to create a more coherent set of incentives, where resources can move more easily with patients and where financial arrangements support, rather than act as a barrier to, service transformation.

Testing our approach

How will we know if any of this has an impact on NHS productivity? The recommendations in this report should be judged by whether they can enable the NHS to deliver better care in practice. We propose two test cases: improving hospital flow (critical for technical efficiency) and developing neighbourhood health (similarly vital for allocative improvement).

1. Improving hospital flow

Hospital flow has been a national priority for years. The problem is not lack of central attention. The NHS has repeatedly responded through escalation, guidance, reporting and short-term initiatives, often focused on individual providers even when the causes of poor flow sit across the whole pathway.

We know many of the potential solutions: better forecasting demand and matching that with supply; discharging patients earlier in the day; and shifting towards a model of 7-day discharge from hospital.[133,134] Even when these solutions are known, the reality is that many barriers and bottlenecks vary in subtle ways across different providers and localities.

Therefore, the centre should set clear guardrails, support transparent evidence and improve the quality of comparable data to understand variations in performance. It should not respond by adding further requirements and assurance, imposing standard national operating models or launching short-term funding pots to pursue targets.

Improvement should not just be left to lone teams. Improving productivity needs to be led locally but supported by systems and regions. If the recommendations of this report are followed, improving flow should be an early regional productivity priority. Regions should convene providers to understand where the diagnostic and change capability is strongest and help pool these resources across organisations or share learning within peer groups.

It should be easier to experiment and test new approaches, while organisations should have more freedom to invest in the resources they need. Where systems improve flow, their success should be celebrated, ensuring recognition of the whole team, from front-line staff to analytics.

2. Developing neighbourhood health

Neighbourhood health should not become another national programme rolled out through a standard blueprint. The centre should provide clarity over funding and transparent planning expectations, define the guardrails and provide the common enablers: outcomes data, evaluation frameworks, contract models, interoperability requirements, information governance, payment rules and planning assumptions.[135] It should not block progress or pressure services to divert funding to meet short-term needs.[136]

Integrated care boards should be the main point of decision making. Working with providers, local government and communities, they should decide the patient groups and pathways that neighbourhood models will prioritise; the resources that need to move; the outcomes to improve; and activity that might need to change, consolidate or stop. They should have the capability to deliver this, including analytical skills.

Medium-term financial planning should support systems and providers to plan ahead, making it easier to strip out fixed costs (eg closing wards) so that neighbourhood models genuinely improve delivery, rather than creating additional demand and activity (which duplicates existing pathways).[137,138] Regions should make variation useful, with good evaluation helping to generate evidence. Models that work should spread. Models that do not should be adapted or stopped.

Table 3: Two test cases for improving productivity

Hospital flow	Neighbourhood health
• Less national prescription of method; clearer national outcomes and guardrails. • Flow treated as a regional productivity priority, not mainly a reporting exercise. • Strong providers supported to share operational and analytical capability with others. • ICBs making explicit resource choices across the urgent care and discharge pathway. • More variation in local methods, but better comparison of outcomes, waits, length of stay, delayed discharge, patient experience and staff experience. • Persistent poor performance addressed through support, peer challenge, recovery milestones and, where necessary, leadership or organisational intervention.	• A clear national purpose for neighbourhood health, but no single national blueprint. • ICBs setting explicit outcomes goals, which neighbourhood models can contribute to. • Planned, multi-year shifts in workforce, estate, digital investment and funding flows. • Contract and payment models that support integrated, preventative and proactive care. • Outcomes and experience data used to judge whether models improve value, not just activity. • Regions evaluating different models, spreading what works and stopping what does not. • Less tolerance of unevaluated pilots, unclear benefits and permanent double-running.

Conclusion

The NHS has long struggled to translate its assets into sustainable productivity growth. This is because there has not been a coherent or conducive environment in which to pursue higher productivity. A health service asked to transform through unstable plans, fragmented accountability, accumulated friction and thinly spread capability will struggle to do so, however strong its ambitions.

We have set out four conditions to break the cycle. A stable direction will make long-term decisions possible. Focused accountability will channel efforts towards outcomes, experience and value. Freedom to deliver will remove avoidable barriers and free up time to redesign pathways and processes. Capability to improve will equip the NHS with the skills needed to diagnose problems, implement better models and learn at scale. Together, these conditions offer a route for the NHS to act on promising opportunities and deliver sustainable improvements to productivity.

Realising these conditions requires a reset of the current operating model, towards a health service that empowers, supports and trusts staff to deliver the best care possible. This should not mean structural change, nor a break with the direction of existing policy ambitions. Our recommendations support longstanding aims including the three shifts in the 10-Year Health Plan and in areas such as medium-term financial planning and the roll-out of integrated health organisations on an evidence-led basis.

Difficult choices will still need to be made. The NHS will have to decide what to prioritise, which services should grow or be consolidated and how to use scarce resources fairly. But these choices will be better made – and more likely to endure – in a system with clearer purpose, steadier rules and stronger capability to act.

The alternative is familiar: repeated recovery drives, shifting priorities, more reporting requirements, piecemeal funding pots and innovation that too often depends on exceptional local effort or leaders. The result is waste, incoherent investments and services poorly designed for the populations they serve. It is an NHS under constant pressure, unable to translate its efforts into better care.

Across the Commission's work, we heard that a more productive NHS is within reach. But it will not be created by asking the system to run ever faster on the same foundations. Instead, it will come from making improvement easier and more durable, enabling the NHS to turn its extraordinary assets into better health, better care and better value in the decades ahead.

Choices will be better made – and more likely to endure – in a system with clearer purpose, steadier rules and stronger capability to act.

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Annex: technical notes

Figure 1: International efficiency analysis

We used data envelopment analysis (DEA) to ask a simple question: given the UK's level of health spending, what outcomes could be achieved if it matched the best-performing comparable countries. DEA identifies an international 'frontier' from the best observed combinations of spending and outcomes. The difference between the UK and this frontier indicates the potential scale of improvement. Similar methods have been used by the OECD among others to benchmark health system efficiency, including analyses based on health-adjusted life expectancy.

The two main outcomes were treatable mortality and healthy life expectancy (HALE). Treatable mortality captures deaths that should generally be avoidable through timely and effective health care. HALE combines the expected length of life with the degree of health experienced during those years, providing an average lifetime measure of population health. The analysis describes observed international differences; it does not identify a particular reform or prove that improved efficiency would cause the entire estimated gain.

Technical specification

- **Countries and years:** the candidate sample comprised the UK and 20 high-income comparator countries. Countries were included only if they had complete data for 2012, 2016, 2019 and 2023. The DEA frontier itself was estimated for 2023; earlier years were used to construct the risk adjustments and ensure a consistent country sample.
- **Input:** each model used one input – current health expenditure per person, measured in US dollars adjusted for purchasing power differences.
- **Outcomes:** treatable mortality was measured as age-standardised deaths per 100,000 and HALE in years. Each outcome was estimated in adjusted and unadjusted specifications, producing six models in total.
- **Population risk adjustment:** a composite risk index was calculated as the mean of standardised exposures to smoking, high blood pressure, high body mass index, high blood glucose, alcohol and particulate air pollution. Exposures were lagged by 5 years: 2007 for

the 2012 outcome, 2011 for 2016, 2014 for 2019 and 2018 for 2023. Outcome regressions included year effects, excluded the UK when estimating the risk relationship and standardised countries to the comparator-sample mean risk level.

- **DEA model:** the analysis used a one-input, one-output, output-oriented DEA model with variable returns to scale, implemented in R using the Benchmarking package. Because DEA treats higher outcome values as better performance, the treatable mortality measure was reversed so that lower rates produced higher scores. HALE, where a higher value already represents better health, was entered directly.
- **Bias correction and sensitivity:** DEA estimates were corrected for small sample bias using 2,000 bootstrap repetitions. Results were then converted into a simple percentage showing how close each country was to the estimated frontier: 100% indicates frontier performance, while a lower percentage indicates a larger gap. Constant returns to scale were tested as a sensitivity analysis. Headline ranges span the adjusted and unadjusted specifications and should not be interpreted as statistical confidence intervals.
- **Geographical interpretation:** the international model is UK based because comparable health spending data are not available separately for England. The HALE result is therefore reported directly as a UK population-level difference in healthy life expectancy. To illustrate scale, the UK treatable mortality gap was applied to an observed England death count.
- **Interpretation:** the frontier represents performance observed among comparator countries at similar spending levels. Results may still reflect unmeasured social, behavioural and epidemiological differences, as well as measurement error. They should therefore be interpreted as benchmark gaps and indications of possible opportunity, not as causal forecasts or guaranteed savings.

Figure 2: Alternative paths for health care spending

Figures are from the OBR's projections of spending pressures over the next 50 years in the fiscal risks and sustainability report (2026) and long-term economic determinants (March 2026). The 'baseline' scenario includes the effect on costs of demographic factors, income effects and 'other cost pressures', which are partly attributed to lower productivity over time. The 'no extra cost pressures in health spending' scenario includes only demographic and income effects. We apply the difference between these two scenarios to the respective future year's GDP, expressed in 2025/26 prices, to estimate the budgetary impact.

We argue that by fully realising opportunities to improve productivity, these additional cost pressures could be avoided or absorbed without requiring health spending as a share of GDP to rise to the extent projected. As we describe in section 3, included in this definition of productivity improvement would be a reshaping of care to better manage changing health care needs, such as due to an increase in chronic conditions.

Figure 5: Admitted pathways per consultant

The chart compares changes in consultant numbers, completed admitted referral-to-treatment (RTT) pathways and admitted pathways per consultant, with each series indexed to August 2015. Activity is measured over the preceding 12 months, while consultant full-time equivalents are shown as a rolling 12-month average. The activity series includes NHS England estimates for missing submissions.

The illustrative counterfactual holds admitted pathways per consultant at their August 2015 level, when the number of completed admitted pathways peaked, and applies that rate to the number of consultants in April 2026. On this basis, around 5.6 million pathways would have been completed in 2025/26 – approximately 1.9 million more than the 3.7 million recorded. This is an indication of the scale of the activity gap, not an estimate of what additional consultants alone could have delivered. It does not adjust for changes in case mix, consultant roles, specialty mix, the pandemic or constraints in beds, theatres, diagnostics and other supporting capacity. RTT figures count pathways rather than unique patients; comparisons with the waiting list should therefore also be expressed in pathways.

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