A 'BROKEN' NHS, £22.6 BILLION AND A BIG REFORM AGENDA

The government's characterisation, and indeed policy, that "*the NHS is broken*", is virtually common parlance. Equally evident is the government's intent to reform the NHS, as demonstrated in recent speeches from the Prime Minister and the Secretary of State for Health and Social Care (SoS), as well as the government's commitment to publish a new 10-year health plan in Spring 2025.

At the Autumn Budget, the government announced that the Department of Health and Social Care's (DHSC) budget for day-to-day expenditure will be £22.6 billion higher in 2025/26 compared to 2023/24. Almost all of this (£21.0bn) will flow directly to the National Health Service (NHS) via NHS England.

This note reviews the state of the NHS and provides a strategic assessment of the government's policies and plans.

CONTEXT: IS THE NHS REALLY "BROKEN"?

The NHS is operating at its limit. It has declined and is exhausted.

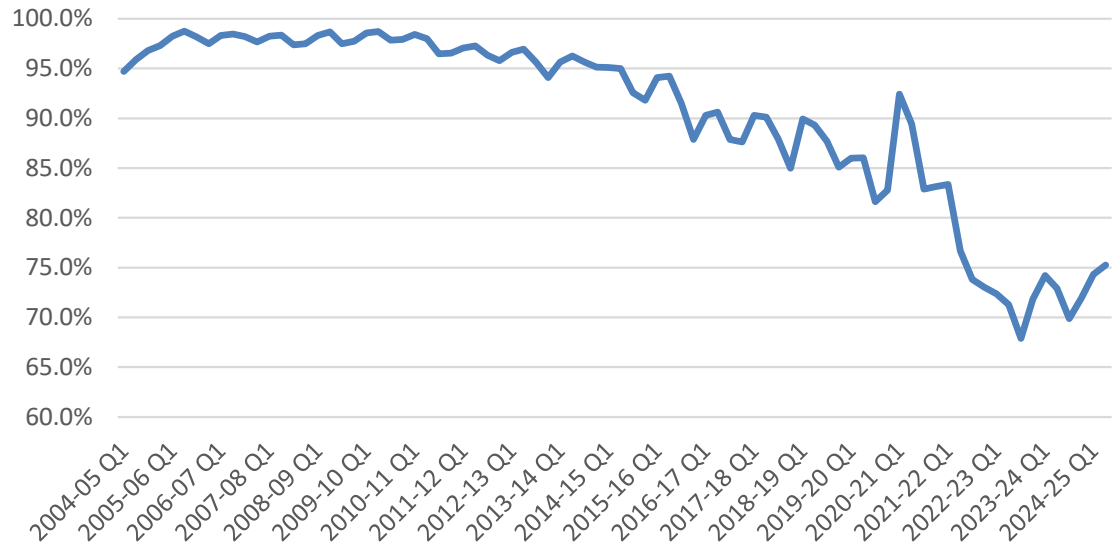
As a diagnosis, the mantra that the NHS is "*broken*" is not too far off the mark, but this requires some qualification.

The recent independent review by Lord Darzi, backed by a wealth of data and analysis, states that the NHS is "*in serious trouble*" and "*in a critical condition*". For example, around 250,000 people have been waiting for elective care for over a year, around one million people are waiting for mental health services, there are significant healthcare inequalities (such as in maternity care), and public satisfaction with the NHS is at its lowest level ever.

Lord Darzi's assessment is supported by analysis from other organisations and experts. A recent international analysis by the Health Foundation finds that the UK has amongst the highest waiting lists for specialist appointments and hospital-based care, and that Covid-19 has left the UK in a "*more precarious state*" than other countries. The latest report by the Commonwealth Fund (2024) – an internationally-recognised comparative assessment of health systems in 10 major OECD countries – gives the UK a low ranking for patient health outcomes and for 'care processes' (which includes prevention, safety and patient engagement).

The NHS's decline is epitomised by Accident and Emergency (A&E) performance. The chart below shows the proportion of A&E patients admitted or discharged within four hours, on average, across England. At national level, the target was previously set at 95% (from 2010), although this has not been met since 2014 – over a decade ago. Revealingly, analysis by the Kings Fund finds that 2024 was the first year that no single individual provider (including the very best hospitals) achieved the 95% benchmark. It is a sign of the times that the NHS is currently targeting 78% by March 2025.

Figure 1: NHS performance for A&E four-hour waits, England, 2004 – 2024



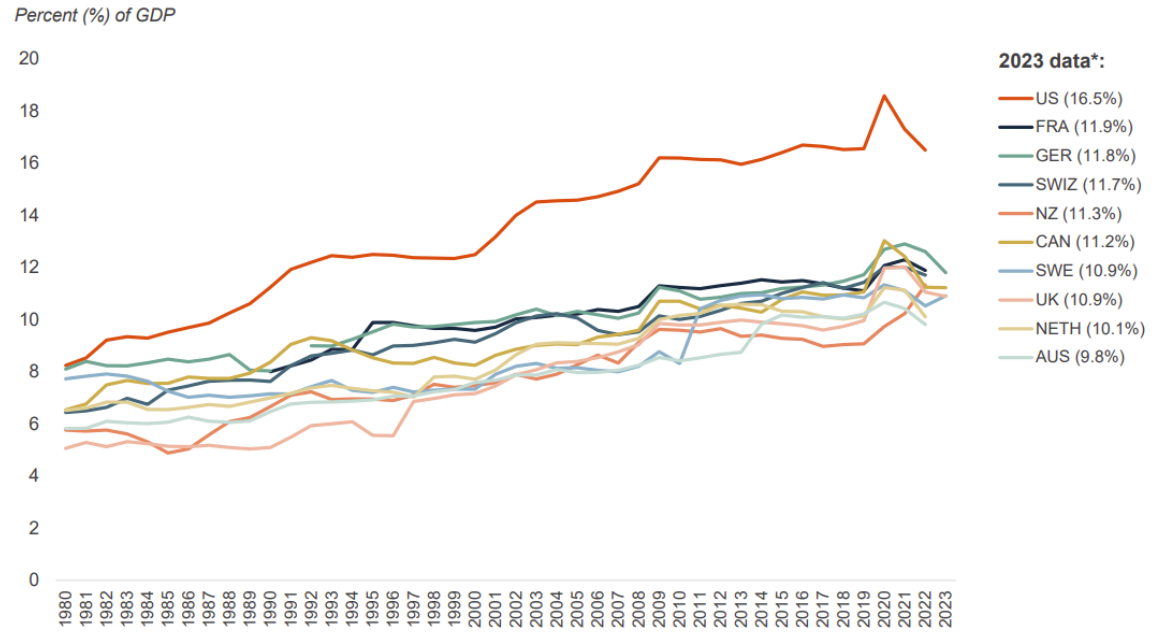
Source: *NHS England (A&E Attendances and Emergency Admissions)*

Strains around health system *outputs* are unsurprising given pressures on health system *inputs*. After temporary boosts to NHS funding following Covid-19, operational financial pressures are back. Prior to the Autumn Budget, NHS planning guidance had assumed zero growth in real terms funding for 2024/25 for Integrated Care Systems (ICSs). Alongside tight finances, staffing shortages (as discussed in the NHS Long Term Workforce Plan) and significant capital backlogs (estimated at almost £14 billion) are well-known pressure points.

But the "*broken*" label is too simplistic as a mantra. The Commonwealth Fund's 2024 report (noted above) still ranks the United Kingdom in 3rd place overall (out of the 10 countries in its assessment), highlighting excellent access to care and administrative efficiency. The dedication of NHS staff during the Covid-19 was undisputed, with some staff willing to wear bin liners during the early stages of the pandemic (in lieu of full personal protective equipment) to ensure that patients received care. The NHS's strong social ethos and founding principles – that care is 'free at the point of delivery' – are a source of national pride and identity.

Furthermore, some of the recent criticisms levelled at the NHS are not unique to the UK. The rising share of GDP (and government revenue) allocated to healthcare is a remarkably consistent trend across many countries, as shown below. The Health Foundation notes that "*pressures on healthcare systems are not unique to the UK*", particularly due to the international nature of Covid-19.

Figure 2: Healthcare spending as a percentage of GDP, 1980 – 2023



Source: Commonwealth Fund, 2024

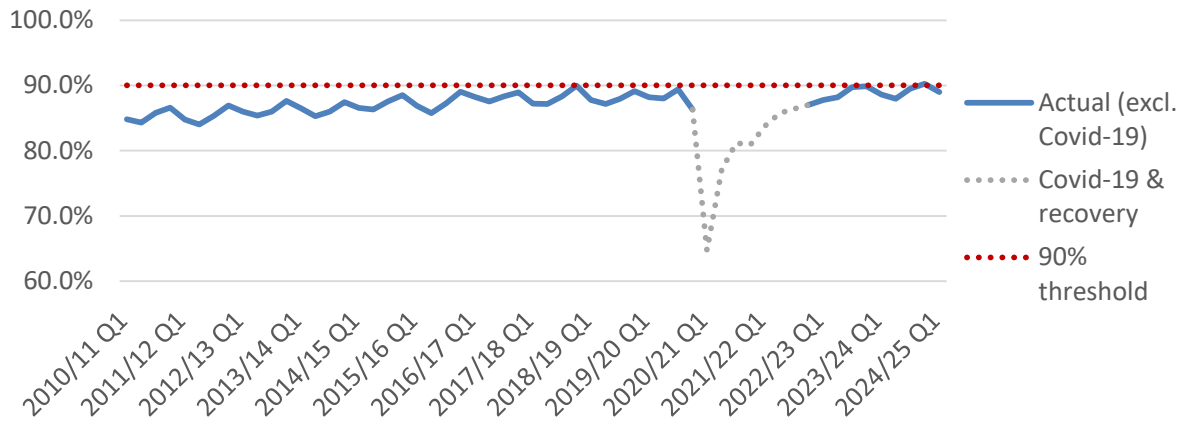
When the NHS looks at itself over time, the decline in certain key performance indicators (such as A&E, shown above) must be placed in the context of growing demand for healthcare and the NHS continuing to set records for services delivered. For example, in October 2024, the NHS experienced the most A&E attendances (over 2.3 million) and emergency admissions (over 565,000) compared to any October on record. Furthermore, the NHS Covid-19 vaccination programme was widely considered to be a success, described by the Kings Fund as "*a near miracle of planning and execution*".

Perhaps one of the reasons that the NHS *may feel* broken is because we have become accustomed to a health service that is world-leading. Only seven years ago, the Commonwealth Fund's 2017 report ranked the NHS in first place in its international healthcare comparison, noting that the UK "*achieves superior performance compared to other countries*" in many areas.

Overall, the "*broken*" characterisation is too simplistic, perhaps necessarily so for a political audience. Fairer descriptors of the NHS would be of '*decline and disrepair*' relative to historic patient experiences and past levels of performance. The Darzi report states, "*the NHS is in critical condition, but its vital signs are strong*".

How can it be true that the NHS is simultaneously a top tier healthcare system, but one that is in a "*critical condition*"? Most likely, it is that **the NHS is continually operating at its limit, without spare capacity**. Bed occupancy rates provide one indicator. In 2018, the National Institute for Health and Care Excellence (NICE) highlighted that there are greater patient risks where bed occupancy exceeds 90%. Since 2010, the NHS (in aggregate) has been ever closer to this threshold, and occasionally has exceeded it. Beneath these national-level statistics, some trusts have even higher rates and in 2023/24 NHS England set trusts an objective for occupancy not to exceed 92%.

Figure 3: Overnight bed occupancy rates, England, 2010/11 – 2024/25



Source: NHS England

A further indication is staff rostering. Since Covid-19, it has become significantly more difficult to fill shifts, due to a combination of rising service demand and staffing shortages. Ultimately, shifts are still filled, but it requires higher levels of effort 'behind the scenes' to find staff. Financial incentives are sometimes also required – such as overtime rates or agency premia – generating further costs. Overall, as the NHS continues to operate at its limit, it must work harder just to 'stand still'.

NHS England states that a lack of spare capacity also aligns with – and helps to explain – the fall in NHS productivity during Covid-19. In the Health Foundation REAL Centre's 2023 annual lecture, Professor Dame Diane Coyle makes this link, stating that pre-existing capacity constraints prior to 2020 led to a "*large contraction in non-pandemic NHS services*" when Covid-19 materialised. When the system is operating at full tilt, it is challenging to manage day-to-day issues, never mind reacting to a global shock.

Finally, "*broken*" or not, we must also appreciate that the NHS also appears '*exhausted*'. It isn't just a mechanical system – the NHS is a care service, delivered by people. Many NHS staff and leaders display extreme dedication to their profession and public service. Amidst the headwinds of financial constraints and demand growth, Covid-19 was the final straw for some. For example, turnover rates for call handlers in one NHS ambulance trust increased from 17.5% in 2020/21 to 28.3% in 2021/22.

Historically, the personal nature of NHS care has posed a significant challenge for governments seeking to improve NHS performance. Even though the *system* may be in decline, a Minister's challenge to reform can feel like a personal insult to staff and local health leaders. Where governments have misunderstood this dynamic, bullish reform proposals have typically been batted back by the provider sector and staff unions, often with the support of the general public. Overall, understanding the NHS's current state requires an appreciation of both technical and personal dynamics.

A NEW GOVERNMENT WITH A NEW(ISH) PLAN

The government has a clear roadmap for NHS reform: It commissioned an independent assessment of the state of the NHS by Lord Darzi; the Autumn Budget allocated additional funding for 2024/25 and 2025/26, with further commitments pending the result of the Spring Spending Review; A 10-year plan is in the making, which will be informed by a public consultation; and the SoS has already revealed several short-term NHS policy themes, including a desire to see "*power shifting out of the centre*".

(1) The government's 10-year plan for the NHS will have some familiar foundations

Whilst the government's forthcoming 10-year plan will bring fresh direction and impetus, the plan's policies will also contain some 'familiar faces'.

First, the Darzi Report's three key themes are not novel, a point which the Secretary of State has acknowledged. Regarding the shift to community care, the NHS Long Term Plan (2019) committed to additional funding to "*boost out-of-hospital care*", such as mental health crisis services. Regarding greater prevention, the NHS Five Year Forward View (2014) devoted an entire section to "*Getting serious about prevention*". Regarding digitisation, attempts to install electronic patient records date back decades, including the government's multi-billion *National Programme for IT in the NHS*, which was launched in 2002 but ultimately never completed.

Second, the fundamental foundations of the NHS are unlikely to alter. In September 2024, the Prime Minister stated that the NHS will remain a "*public service, publicly funded, free at the point of use*". More recently, a DHSC spokesperson was quoted as saying that: "*Lord Darzi's investigation found nothing that 'draws into question the principles of a health service that is taxpayer funded, free at the point of use, and based on need not ability to pay'*".

Radical proposals cannot be ruled out *definitively*, as government commitments may subsequently be reviewed or nuanced. However, such changes are extremely unlikely. DHSC's explicit reference to "*taxpayer funded*" healthcare (see above) suggests that fundamental shifts – such as European-style healthcare insurance, or Australian-style insurance top-ups – appear to be off the table. Any reforms that threaten the equitable nature of the NHS, either in actuality or perception, would likely raise significant opposition and could risk undermining the stakeholder buy-in needed to implement wider policy reforms.

Third, several of the government's recent announcements share similarities with previous NHS strategies and policies. The SoS's announcement of a return to "*local commissioning*" – led by ICBs – implies a shift in emphasis back towards the commissioner-provider separation initiated during the 1990s. The proposal for government hospital league tables is a reincarnation of a New Labour policy during the early 2000s. (Note: NHS England already has a ratings system in place for providers – called the NHS oversight framework – but this is less overt than a government league table.) The SoS's desire to give high-performing hospitals more autonomy is an extension of the Foundation Trust model implemented in the mid-2000s. Finally, the government's NHS public consultation is reminiscent of an NHS England initiative in 2013, which stated the following: "*NHS England has today called on the public, NHS staff and politicians to have an open and honest debate about the future shape of the NHS in order to meet rising demand, introduce new technology and meet the expectations of its patients*."

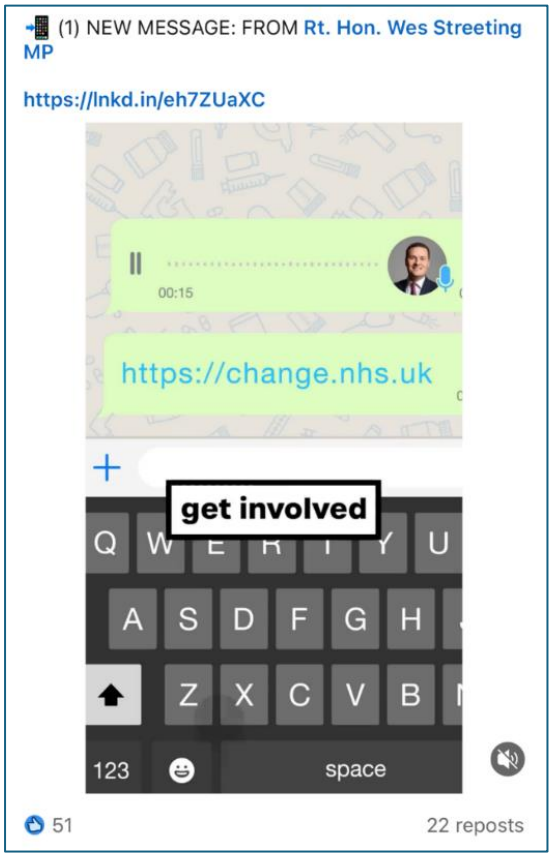
There is nothing intrinsically wrong with revisiting and/or evolving historic policies. However, as the government seeks stakeholder buy-in for the forthcoming 10-year plan, it will need to leverage lessons learned from history and overcome potential pessimism from seasoned NHS leaders and staff who have worked through previous iterations.

(2) Some parts of the government's 10-year plan may already be well-formed

DHSC has established a series of working groups to support the development of the government's 10-year plan, due in Spring 2025. Four will cover the future vision for the NHS (self-health management, access to care, integration and equity), whilst the other seven groups consider enablers of reform. Ministers have made clear that Lord's Darzi 'triple jump' of reforms – from analogue to digital, from hospitals to home care, from treatment to prevention – will be a fulcrum of the government's policy agenda.

The government has widely-publicised its open consultation on the NHS ("*Change NHS*"), utilising a range of media channels. For example, you may have received a 'message' from the Secretary of State via your LinkedIn feed (see below).

It remains to be seen whether the public NHS consultation is more a *core policy driver* or a *finishing touch*. For example, in a recent interview, the SoS stated that the NHS consultation will be used to "*finalise*" the 10-year plan, so some components of the plan may be well-considered already.



The role of patient engagement within health service design is typically more of an art than a science. On one hand, as the SoS recently stated, "*power to the patient is my mantra and it needs to be yours, too*". On the other hand, as the largest employer in Europe, the NHS necessarily requires national direction around how healthcare services are structured. These are not necessarily mutually exclusive: The SoS is targeting a combination of national strategy and local delivery, alongside greater personal choice and flexibility for patients.

Independent of the role of the NHS public consultation, it should be viewed as a positive that some major themes within the 10-year plan will already have been under consideration and development by government and trusted stakeholders. It would be much more concerning if the government had come to power without itself having a clear vision for the NHS, given the scale of the potential reforms ahead.

(3) The government is willing to go big: Look out for some 'wild card' proposals

Alongside many 'familiar faces', the government's plan will likely also include some radical proposals, with at least a few making their way into the final 10-year plan. This is evident from the SoS's recent conference speech, which – at least in tone – constituted a break from recent years.

There are further reasons to suspect big changes are on the way. The Lord Darzi report has provided a clear mandate (and political justification) for reform. The government's public consultation (*Change NHS*) has explicitly invited new ideas into the public sphere. Alan Milburn – recently appointed as non-executive director at DHSC, and previously an NHS reformist with New Labour – recently asserted that the NHS needs "*a massive dose of reform*".

Of the vast range of potential reform options, one highly probable intervention is a ban on certain types of agency staff. Although not specifically discussed during the SoS's conference speech on 13th November, this was trailed in national media on 11th November. The NHS LTWP sets out that spend on temporary staffing grew by around 40% in the three years up to 2021/22. Agency staff are less likely to provide continuity of care and are typically more expensive – which increases organisational costs and may create disharmony with permanent, full-time NHS staff.

The challenge for trusts is that reducing agency spend is not always a credible position to take, particularly during staffing shortages. If

a trust seeks to hold firm to a 'no agency staff' rule, it risks comprising patient safety in the short term. A government directive, undertaken with consideration of any trade-offs, appears to be the best solution to improve credibility. However, different implementation options have pros and cons. For example, an immediate ban (rather than a glidepath) gives providers a clear policy to lean upon, but it might increase risks to services in the short-term. If trusts fear risks to patient care, it could lead to 'workarounds' or creative solutions.

Second, could the government tinker with private healthcare arrangements? For example, if individuals receive incentives (such as additional tax breaks) to purchase private healthcare insurance, that could reduce the burden of demand on the NHS, without the government changing NHS policy specifically. Such tax adjustments are more technical in nature (so less likely to garner media attention) and could align with the government's aims to encourage self-care and prevention.

However, such interventions might have negative indirect implications. First, it could widen inequalities in health outcomes, as wealthier individuals would be more likely to take-up private insurance and would therefore benefit the most. Second, given existing staffing shortages, an expansion of private healthcare facilities (induced by more individuals having private health insurance) could risk existing NHS staff switching to private providers, thereby further undermining the NHS staff base.

Third, fines for missed NHS appointments might be considered. This idea was raised – but then abandoned – by the Sunak Conservative government. Technically, it would not contradict core NHS principles because services would continue to be free, and the fine would be a charge for *not* using NHS services. Care Minister Stephen Kinnock has stated that fines for patients are not in the government's plans, suggesting that there are alternative, less divisive approaches to improving attendance rates, such as online bookings and electronic reminders. However, if the *Change NHS* consultation provides strong public support for this policy, and if it could be administered without generating additional burden for GPs, this option could be revisited.

Fourth, funding, incentives and payment models are an area to monitor. The SOS has signalled a much greater focus on local accountability, and it would be surprising if the government did not mirror this through amended funding rules and allocations. The SOS has already made some commitments in relation to capital funding, stating that ICBs which "*demonstrate the best financial management will get a greater share of capital allocation*". However, this could go further, including through updated allocation approaches and financial incentives across primary and secondary care.

If incentives or payment models are refined, there are several issues for consideration. Proposals such as the SOS's capital allocation incentive (discussed above) rely on the ability to accurately measure performance – otherwise financial balance may be prioritised over care quality. There are also differentials between types of care: Hospital funding varies with the level of activity delivered, whereas primary care funding is largely driven by a practice's local population (*capitated* payments). This distinction arose initially for sensible reasons – hospital activity is more episodical whereas primary care is more continuous and holistic – but the current structure implicitly disincentives the 'shift to the left' (more prevention and early-stage care).

Public healthcare systems experience a perennial challenge of balancing between incentives and equality. By rewarding the best performers, funding incentives may inadvertently widen the distance between the best and worst hospitals. This issue is exacerbated where metrics are imperfect indicators of performance. Reimbursing providers based on outputs (such as patients treated) can potentially improve performance but also distort behaviour at provider level.

Regarding performance measurement, the NHS would like to incentivise patient (health) outcomes, but these are not perfectly correlated with organisational performance. For example, a local authority's decision to constrain social care funding can indirectly increase demand for NHS bed capacity.

Finally, healthcare incentives need to encompass both financial and wider factors. Healthcare leaders and staff are typically motivated by public service, recognition and reputation – alongside pay and wider financial rewards – so designing incentive structures in healthcare requires a relatively wide set of considerations.

(4) Reforms will need effort to implement – even without a top-down reorganisation

The government appears to be steering clear of a top-down reorganisation of the NHS. However, reforms will still require plenty of 'rewiring' – due to revised responsibilities, ways of working and services delivered.

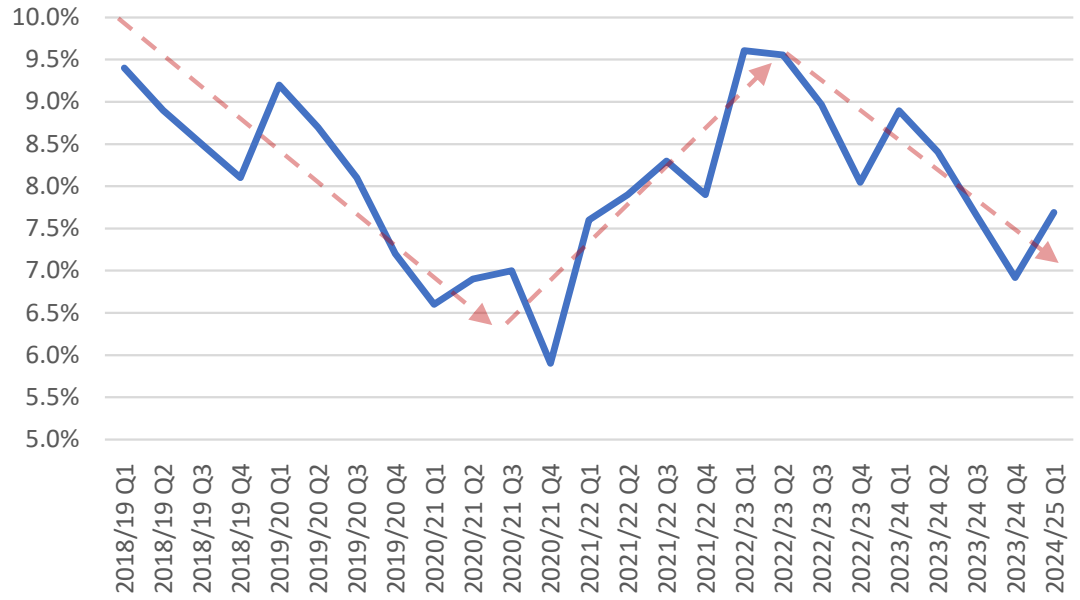
At ICS level, there are two important changes to its roles and responsibilities, both of which appear relatively straightforward, but which will require concerted local action to achieve in practice. First, the SoS has emphasised ICSs' role in *commissioning* activity. This differs in focus from the increase in collaboration between ICSs and providers in recent years. Even if it facilitates a 'healthy tension', organisations will have to adjust to the new dynamics and build capacity. Second, ICBs will need to meet their new "*big*" responsibility from the SoS to develop "*a new neighbourhood health service".* Whilst neighbourhood teams are partly an extension of existing efforts towards joined-up care across primary and community services, the NHS Confederation states that it "*requires a new proactive model of care that works more effectively with communities and wider partners*", which goes beyond simply shifting medical activity into the community.

The interaction between providers and national organisations will also require time and effort to redesign. The SoS has made clear that NHS England – not ICBs – will oversee trust performance. In theory this sounds straightforward: NHS England retains the regulatory functions of Monitor (the former NHS regulator) following its incorporation into NHS Improvement, and the subsequent merger with NHS England in 2019. However, in practice, regulatory dynamics take years to establish and perfect. With a shift in recent years towards devolved decision-making and greater collaboration, a shift in emphasis back towards regulation and national oversight will require concerted efforts to implement effectively.

(5) Short-term uncertainty remains around national workforce planning

Since the Covid-19 pandemic, staffing shortages have increasingly been a constraint to NHS service delivery. Despite considerable progress to reduce staff turnover during the late 2010s – including through a national retention programme – vacancies rose again during the early 2020s, due to a combination of Covid-19-related absences, rising service demand (e.g. recovering elective activity), and rising workloads and burnout. This trend was accompanied by an increase in expenditure on temporary staffing. There is some optimism due to falling vacancy rates since 2023, supported by higher pay awards for NHS staff. However, underneath the headline aggregate metrics there continues to be considerable variation in staffing shortfalls – between regions of the UK, between different staffing groups, and between different healthcare sectors.

Figure 4: NHS staff vacancy rate, England



Source: NHS England, NHS Vacancy Statistics

Against this backdrop of staffing shortages, the much-anticipated NHS Long Term Workforce Plan (NHS LTWP) was published in 2023. It included commitments to £2.4 billion additional funding towards education and training up to 2029, including a 27% increase in NHS training places. However, the current government is yet to formally endorse the NHS LTWP. As such, national workforce strategy – for the moment at least – remains in a holding pattern.

"*People*" (which includes staffing) is one of the seven working groups for the 10-year plan (noted above), so the government will likely seek to develop a revised workforce strategy alongside its work on the 10-year plan. Senior nursing officials recently revealed that a refreshed workforce plan is planned for publication in Summer 2025. The timing would align nicely: A refreshed workforce plan is a natural follow-up to the overall NHS 10-year plan planned for Spring 2025.

Some temporary uncertainty around the NHS workforce is not unsurprising. Amidst a constrained fiscal environment, the NHS LTWP comes with a relatively high price tag (noted above). Given vacancy rates have fallen since 2023, there is value in allowing time to assess whether current trends might continue. The NHS LTWP itself notes that it would be subject to evolution, stating that "*the intention has always been for the Plan to be iterative*", so some tweaks to assumptions and initiatives were always likely. Finally, the government will want to ensure that its workforce strategy – including any significant funding commitments – aligns with (and is prioritised alongside) its wider 10-year plan.

KEY TAKEAWAYS FOR THE NHS FROM THE AUTUMN BUDGET

Funding is not the only driver of NHS performance, but it certainly is a material one, and therefore the Autumn Budget sets the stage for the NHS in the coming years. The Budget sets out NHS funding to 2025/26 and wider public sector expenditure up to 2029/30.

(1) A pragmatic budget for NHS day-to-day spending

From the perspective of the NHS, the Autumn Budget ended up providing a healthcare allocation close to what might be expected of a Labour government. However, it took a communications rollercoaster to get there.

With the government's manifesto pledge to "*deliver stability with iron discipline, guided by strong fiscal rules*", and the Prime Minster's announcement that there would be "*no more money without reform*", pre-Budget funding predictions were pessimistic for the NHS.

In contrast, on Budget Day itself, the communications were more effusive, announcing that the annual NHS budget will rise by approximately £21bn over the next two years. This was publicised as "*the biggest increase in NHS spending since 2010, excluding COVID-19 years*".

Across these two extremes, the NHS revenue (RDEL) funding settlement is – objectively – somewhere down the middle.

First, the stated 4% real growth rate in NHS funding (cumulative annual growth rate, or CAGR) is only marginally higher than the NHS's historic long-run funding CAGR (3.6%). This is significantly above NHS funding growth since 2010, but is notably below funding growth rates under New Labour (closer to 6%). Moreover, when accounting for funding transfers between DHSC and NHS England in 2023/24, the Health Foundation estimates that real terms funding growth in 2024/25 is actually closer to 3%, which would be slightly below the long-term average.

Second, the Autumn Budget funding announcement is unlikely to achieve significant reform, when considered in the context of current and future pressures. A large portion of the increase in NHS funding simply covers recent pay awards: Analysis by the Nuffield Trust – which combined the impact of pay deals and higher pensions with expenditure growth at month 4 (2024/25) – suggests that the Autumn Budget should allow the NHS to roughly break even in 2024/25. Moreover, the funding uplift for 2024/25 comes over halfway through the financial year, which limits the flexibility with which it can be deployed towards new or transformative initiatives. Looking ahead, the Budget has front-loaded public sector funding growth across the government's five-year term, so the NHS cannot bank on similar levels of funding growth after 2025/26.

The Autumn Budget was a pragmatic choice, with the Chancellor caught between a rock and a hard place. On one hand, 2024/25 has seen significant pay rises for NHS staff, creating in-year financial pressures. Less funding for the NHS would have risked early disapproval from NHS leaders and early media criticism likening the government's economic strategy to "*Austerity 2.0*". On the other hand, the Prime Minister stated in September 2024 that "*we have to fix the plumbing before turning on the taps*" – referring to NHS reforms and funding. Disbursing too much funding would have reneged on this challenge and would have further rationed resources to other government departments.

In practice, even though the *plumbing hasn't yet been fixed*, it was too great a risk to *turn off the taps*. The Autumn Budget, in providing funding growth close to the NHS historic average, will allow services to continue in 2024/25 and 2025/26 without material threat of constraints. This allows the government to develop its 10-year plan without significant risk of short-term service deterioration.

(2) The government is right to increase the capital budget, although it largely reverses previous shortfalls.

The increase to the capital budget for the Department for Health and Social Care (DHSC) – from £10.5bn in 2023/24 to £13.6bn in 2025/26 – equates to a real CAGR of approximately 11% over the next two years. This is slightly higher than growth since 2020, and by far exceeds outturn capital spending growth during the 2010s (of circa 1% real CAGR), which was hindered by over £4bn of capital-to-revenue switches during the latter 2010s.

Capital growth is needed badly to offset significant shortfalls. The estimated value of backlog maintenance in the NHS was largely constant during 2005 – 2015 (at around £4bn in cash terms), but has more than tripled since

then, rising to almost £14bn. £2.7bn of this backlog is classified as 'high risk', defined as "*repairs/replacement [which] must be addressed with urgent priority in order to prevent catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution*".

Poorer quality facilities risk disruptions to services and sub-par patient care. As an example, NHS England estimates that in the last two years there have been 12,000 reported incidents of estate failures (such as electrical faults and leaks) which have disrupted clinical services. Deteriorating assets also incur additional operational expenditure due to wear-and-tear.

The Darzi report provides an even starker perspective on the capital funding shortfall. It highlights that the NHS spent £37bn less than comparator nations during the 2010s, which would not only have covered the maintenance backlog but also would have funded the previous government's new hospital programme. Analysis by the Health Foundation demonstrates that most other European countries have materially increased the value of national healthcare assets in recent decades, whereas the UK's healthcare capital fell during the period 2000 – 2017.

Recent research by the London School of Economics (LSE) provides support for greater capital investment, in finding that relatively low capital expenditure is a key driver of the UK's recent poor productivity performance. The economic fruits of capital investment are typically not seen in the short term, but rather through longer-term productivity and performance.

(3) The 2% productivity target in 2025/26 (and possibly beyond) is stretching

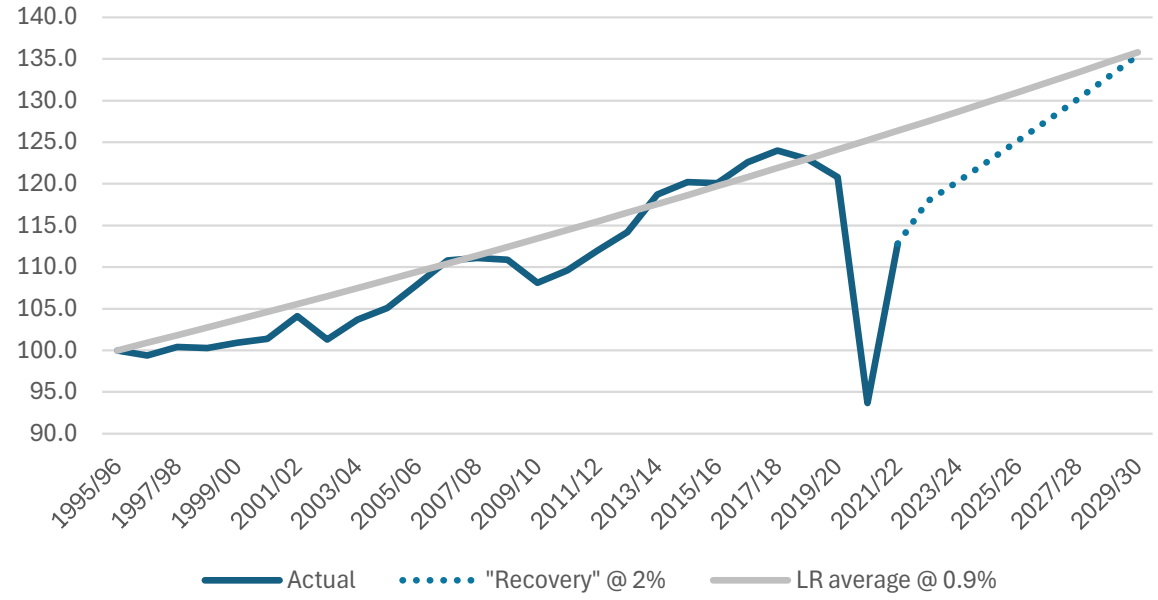
The 2024 Autumn Budget announced a "*renewed focus on public sector productivity*". All government departments' budgets (including DHSC and the NHS) factor in a productivity assumption of 2% per annum for 2025/26.

To date, the government has set this 2% target for one year (2025/26), with targets for future years pending the upcoming Spring Spending Review. However, 2% productivity would align with the targets previously set by the Conservative government up to 2030: The 2024 Spring Budget committed the NHS to delivering four years of productivity growth (from 2025/26) at approximately 2% per annum. In addition, 2% productivity broadly aligns with the 1.5%-2.0% productivity range assumed within the NHS Long Term Workforce Plan (albeit that target was specific to labour productivity).

On one hand, there is an intuitive logic to a productivity target of 2% per annum. The chart below illustrates that 2% per annum productivity growth would allow health sector productivity to catch-up to its longer-term trajectory by 2030, effectively as if the Covid-19 productivity dip had never happened. With trends towards virtual care (e.g. virtual wards, remote monitoring, online consultations), opportunities for productivity have materially expanded versus the pre-Covid environment, so one view is that it should be possible *in theory* to recover productivity to the long-term trend. A recent report by the Institute for Fiscal Studies (IFS) – focusing on acute hospital activity specifically – provides scope for optimism, observing significant activity growth to date in 2023 and 2024, despite industrial action.

For context, the long-term trend of productivity growth is approximately 1% per year. ONS public service healthcare quality adjusted productivity indices from 1995/96 to 2018/19 indicate an average of 0.9% productivity per annum. The University of York's Centre for Health Economics publishes an alternative productivity index for the NHS but finds similar results. Taking a shorter time period (2004/05 to 2018/19), both the quality-adjusted ONS measure and the University of York's measure estimates productivity growth at 1.1% per annum.

Figure 5: Healthcare productivity growth, England



Source: ONS, ONS

Note: Whilst 2022/23 productivity is not yet published, this chart incorporates experimental ONS data which estimates that healthcare productivity was approximately 4% below the long-run average trend in 2022.

However, there is an alternative perspective: That achieving 2% productivity per year up to 2030 is both stretching and ambitious.

First, some productivity growth to date may have been achieved via an unsustainable rationalisation of resources. For example, ONS data (see chart above) shows that productivity grew more quickly during the austerity of the 2010s. During this period, funding growth was lower, and service performance started to decline (albeit with a lag) – as evidenced by declining performance for four-hour A&E waits. Whilst productivity targets can press providers to improve efficiency, *genuine* productivity requires that gains are also sustainable.

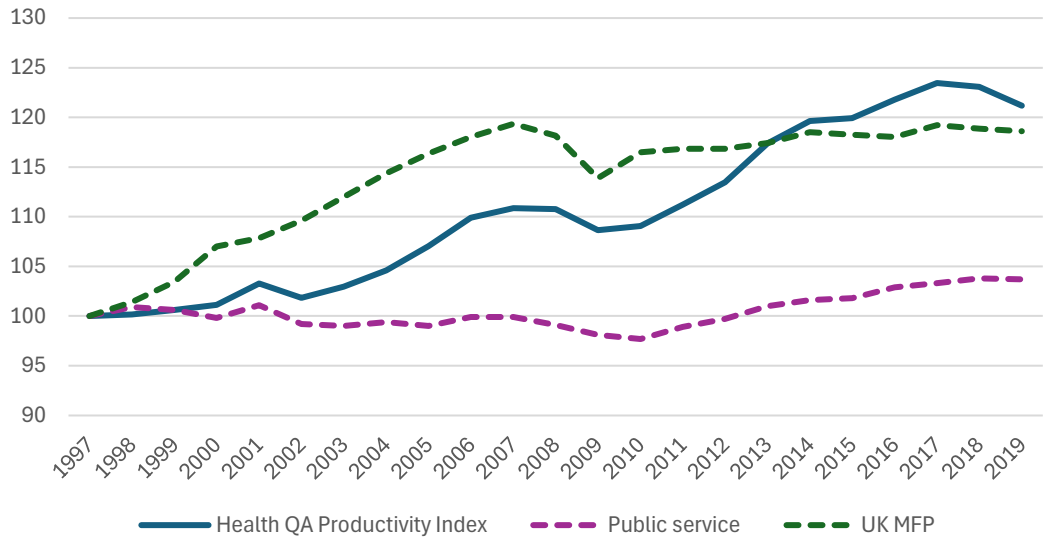
Second, other public sector services and the wider economy do not appear to be surging ahead of the NHS in terms of productivity.

Cumulatively over the last two decades, pre-Covid, ONS productivity growth in healthcare far exceeded productivity growth across the public sector overall, and was even slightly higher than total (multi-) factor productivity growth across the UK economy by 2019. This is shown in the chart below.

If healthcare productivity growth were below other sectors, this might imply scope for efficiency gains in the NHS, but this does not appear to be the case. The 2019 NHS Long Term Plan (published pre-Covid) targeted productivity gains of "*at least 1.1% per annum*" – a notable discount on the 2% target announced at the Autumn Budget.

Moreover, productivity *forecasts* for the UK economy overall over the next five years are similarly moderate. The Office for Budget Responsibility's (OBR) October 2024 *Economic and Fiscal Outlook* forecasts productivity growth of approximately 1% per annum on average across the period 2024-2029 inclusive.

Figure 6: Productivity growth for healthcare, the public service and the UK economy



Sources: ONS, ONS, ONS

Notes: QA = Quality-adjusted productivity; MFP = Multi-factor productivity.

A further, forward-looking factor that may constrain the NHS's ability to deliver high rates of productivity is the historic tilt of funding away from workforce and capital budgets and towards frontline day-to-day spending. During the 2010s, a sequence of capital-to-revenue switches was undertaken (discussed above) and the proportion of health funding allocated to education and training fell from 5% in 2006/07 to 3% in 2018/19. Research from LSE finds that the UK's recent poor productivity performance is largely due to "*a lack of investment in capital and skills*". Historic cuts to capital, education and training – which are identified as key drivers of productivity – increase the challenge of the NHS achieving 2% growth in a sustainable manner.

Significantly, the 2% productivity target effectively constitutes a minimum target for providers. As an example, one Integrated Care Board (ICB) is planning to deliver a 6% efficiency gain in 2024/25 in order to achieve in-year financial balance. In a survey by NHS Confederation, over 50% healthcare system leaders are concerned that they will require top-up funding in 2024/25 and/or are unlikely to hit their efficiency targets.

In addition, future productivity may be hindered by the erosion of staff goodwill, which historically has generated discretionary effort to support patient care. This trend is hard to quantify but – anecdotally from senior clinicians – goodwill has receded in recent years due to high workloads and tensions between the government and staff unions. For example, Dr Chaand Nagpaul – BMA Chair of Council until 2022 – has emphasised the importance of staff goodwill in sustaining the NHS historically, and has warned that "*rapidly diminishing*" goodwill could effectively reduce NHS capacity.

Finally, regardless of the level of productivity growth required, the language and framing of the productivity target is important in terms of buy-in with providers and staff. For example, the Prime Minister recently told a group of NHS staff at a press conference that "*your workload is likely to go up, not down*". Likely, this was a well-intentioned attempt to explain productivity from a technical perspective: That higher labour productivity is the mathematical consequence of existing staff delivering more activity. However, the phrasing inadvertently sounded like a directive to *work harder*. With survey data finding that a third of NHS staff

find their work "*emotionally exhausting*", communications are an important component of the government's productivity target.

(4) Without big reforms, the challenge facing the NHS appears extremely steep

The NHS has a funding envelope up to 2025/26, as discussed above. Beyond that, NHS funding is not yet known. However, the Autumn Budget did announce the overall spending envelope up to 2029/30 for government departmental day-to-day spending (RDEL). Once adjusted for inflation forecasts, RDEL will grow by approximately 1.3% per annum in real terms between 2025/26 and 2029/30. There are several permutations to achieving this, but all three options below would constitute a significant challenge.

First, the government could grow all departmental budgets equally, by 1.3% per year in real terms. Applying this growth to the NHS would only marginally exceed the 'austerity' funding of approximately 1.1% real CAGR during 2010 – 2015.

Second, the government could allocate more of this funding towards the NHS. Given that healthcare constitutes roughly 40% of government expenditure, if the NHS budget grew by around 3.3% per annum (real) per annum, it would require all other departmental budgets to be held flat in real terms in order to maintain the Budget's overall fiscal envelope.

Third, the government could increase its funding envelope for the remainder of the term. Under current forecasts for economic growth, higher spending would almost certainly require higher taxation or borrowing.

There are circumstances in which these three scenarios could be avoided. If the NHS can substantially increase productivity through reforms, it may be able to maintain services with a lower funding growth rate. Or if the economy can grow faster than OBR projections, government spending could rise without higher taxation or borrowing. However, these circumstances are far from guaranteed.

IMPLICATIONS FOR THE NHS BASED ON WHAT WE KNOW SO FAR

(1) More NHS funding could be required in 2025/26

Whilst the Chancellor and SoS will scrutinise DHSC and NHS finances over the next 18 months – given the additional allocation of £22.6 million – further funding top-ups may be required.

First, as noted above, additional NHS funding has been committed at the Autumn Budget *before* reforms have been negotiated or agreed. The upside of the government's approach – in allocating financial headroom to the NHS early in its term – is that it treats NHS leaders as adults and experts who understand how to deliver reforms 'on the ground'. But there is a cost in terms of the government's influence: Whilst the Prime Minister's opening position was conditional ("*no more funding without reform*"), the SoS's recent statement is more managerial ("*we've got to make sure that the investment the chancellor has committed to the NHS is linked to reform*").

Second, cost pressures are likely to persist. Recent staff pay deals were quickly-agreed, which sets a precedent for other groups. For example, pharmacies are the latest group to issue service warnings, and nurse unions communicated their 'rejection' of this year's 5.5% pay award. Constraints around hospital discharge will continue to inhibit hospital productivity gains. For example, an estimated 13% of NHS beds are occupied by people waiting for social care or other out-of-hospital support. The £600m increase in funding for social care announced at the Autumn budget is unlikely to significantly shift these constraints, as it constitutes approximately 2.4% of annual Local Authority expenditure on adult social care. Media reports highlight that there is a government 'impasse' around a long-term plan (with associated funding) for social care. Even if the NHS can successfully deliver reforms, they will likely take time and involve short-term double-running costs.

Third, NHS annual budgets have recently been subject to revision. For example, the NHS budget for 2023/24 – originally set in 2018 to accompany the NHS Long Term Plan (2019) – was subsequently revised upwards in 2021, 2022 and 2023. Whilst this largely relates to funding requirements for post-Covid-19 recovery efforts, nonetheless it illustrates the challenge of holding firm to fiscal plans when healthcare services and individuals' lives are at risk.

Figure 7: NHS funding baseline and adjustments

£ million	2019 to 2020	2020 to 2021	2021 to 2022	2022 to 2023	2023 to 2024	2024 to 2025
NHS funding baseline	120,807	127,007	133,283	139,990	148,467	151,629
Accounting classification adjustments	*-2,043*	*-2,341*	*-2,641*	*-3,293*	*-3,321*	*-3,442*
Revised Baseline	**118,764**	**124,666**	**130,642**	**136,697**	**145,147**	**148,187**
Pensions adjustment	2,851	2,851	2,851	2,851	2,851	2,851
Additional COVID-19 and elective recovery funding		19,988	16,295			
Spending Review 2021 funding				8,989	6,085	8,161
Autumn Statement 2022 funding					3,300	3,300
Autumn Statement 2023 funding					1,114	
Supplementary Estimates 2023 to 2024 funding					2,062	
Other transfers of funding prior to Spring Budget 2024	-281	-373	-1,815	6,691	2,627	
Spring Budget 2024 funding						2,450

Source: 2024 to 2025 financial directions to NHS England

(2) It will be challenging for the government to remain 'hands off'

Since the publication of the NHS Long Term Plan (2019), the NHS has emphasised local collaboration and decision-making, formalised through the creation of Integrated Care Systems (ICSs). The SoS has stated that local decision-making will be strengthened via a "*triple devolution*" of power to ICBs, providers and patients. However, the NHS's high profile and current strains make it extremely challenging for the government to step back too far.

First, as discussed above, the government has already announced a large NHS funding uplift and will need to ensure that the NHS 'delivers' on this. As noted above, the SoS has stated: "*We've got to make sure that the investment… is linked to reform*."

Second, improvements to public services – and particularly the NHS – are major political priorities for the government. The Autumn Budget prioritised public sector expenditure, in exchange for higher taxes and borrowing. If the government can deliver materially improved public services, the higher expenditure can be justified. But if services do not improve, the government could face criticism for its economic strategy, particularly as OBR analysis suggests that the majority of higher Employers National Insurance Contributions (ENICs) will indirectly be sourced from wages.

Third, strategic decision-making has shifted slightly closer to government in recent years. For example, the 10-year plan is primarily led

by DHSC, whereas the previous NHS Long Term Plan (in 2019) was authored by NHS England. Since the introduction of the Health and Care Act 2022, the Secretary of State has an expanded range of powers, including discretion to approve or reject a proposed service reconfiguration.

Fourth, the SoS has signalled his desire for rapid performance improvement, stating that "*crack teams*" will challenge and support local healthcare services. For example, a recent government source stated that the SoS will be giving the NHS "*its marching orders for next year, where we want to get to and what we need to change to get there*". At least, with the government having a strong parliamentary majority, NHS local leaders can expect greater stability over at least the next five years, which may help to achieve buy-in for the government's strategic vision.

(3) Top-quality NHS local leadership will be at a premium

As an extremely large organisation, the NHS is no stranger to accusations of being bureaucratic. DHSC prescribes objectives and performance metrics in its *mandate* to NHS England. In turn, NHS England issues planning guidance and national guidelines for ICSs and providers, with NHS England regional teams providing oversight and local support. Governance and accountabilities are a regular source of debate.

The SoS has announced that greater autonomy will be devolved to local organisations – as part of a 'triple devolution' of power (see above). Alongside more autonomy, there will be greater challenge if providers fail to perform.

In this context, leaders and organisations will now likely be more exposed and judged more critically based on their performance. The most effective leaders will be given more freedom to innovate and deliver improved services. For the least effective providers, the SoS has stated that there will be "zero tolerance".

Furthermore, the government is adopting a more straight-talking approach with ICBs and providers. The SOS recently stated that he is seeking to "*lay down some direction*". For systems and providers seeking to engage with the government and NHS England around performance issues, leaders will need to have confidence, a deep understanding of their services, and an ability to demonstrate success.

The government's fresh impetus towards NHS performance improvement will require a careful balance. Compared to previous decades, there is a greater appreciation for executives' mental health and wellbeing, so the government will need to combine challenge with support and care. Furthermore, if the system *as a whole* continues to struggle – as per the decline in A&E performance in recent years – the government would likely need to acknowledge the material influence of factors outside of management control.

SUMMARY

This note analyses recent government policy announcements and the Autumn Budget, within the context of the current state of the NHS.

The government and the NHS – collectively – face significant challenges over the next five years. Funding limits, productivity requirements and stakeholder dynamics are all likely to be severely tested. Whether the NHS is at – or beyond – it's breaking point, there is clear evidence that its performance has declined over time, both prior to – and as a result of – the Covid-19 pandemic.

Alongside continued operational and financial pressures, NHS providers are expected to receive greater autonomy, but with greater responsibility for performance improvement. This places a high value on local leadership.

However, the government will likely find it challenging to remain 'hands off'. Its political strategy and current fiscal trajectories are contingent on successful NHS reforms that both improve public services and deliver productivity gains.

Finally, a new government does present a window of opportunity. Let us hope that the NHS can continue to build upon its many strengths and can find healing for its troubles.

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