Measuring what matters: NHS's new methodology to measure productivity

Experts in health

NHS England recently published its trust-level productivity methodology. Every NHS trust in England now has a productivity score that will be published monthly. The Spending Review target is clear: 2% productivity growth, year on year, until the NHS returns to pre-pandemic levels. Understanding what the productivity metric actually measures, and what it doesn't, has never been more important.

What the framework does

At its core, the methodology asks a simple question: "**for every pound spent (in real terms), is the NHS delivering more care than it did in the same period the year before?**" It does this by comparing two things:

- How much activity a trust has delivered
- And how much it has spent delivering it across equivalent time periods

If activity grows faster than spend, productivity improves. If spend outpaces activity, it falls. The calculation divides the two growth rates rather than subtracting them, which means a trust growing activity by 10% whilst costs rise by 5% sees productivity grow by 4.8%, because that output growth is being expressed relative to a cost base that has itself expanded.

Cost weighting: activity is not just counted, it is value-adjusted. For example, a complex surgical episode counts for more than a routine outpatient appointment, weighted by national average unit costs. This means a trust shifting toward higher-acuity work will see the change in complexity mix reflected in its productivity metric.

Equalisation: This is the important design choice in the methodology. Moving patients from elective overnight stays to day surgery is clinically right and financially sound. Without equalisation, it would make a trust look less productive, because day cases carry a lower unit cost. The methodology corrects for this, assigning equivalent cost weights to equivalent outcomes. It is designed to reward the shift to lower-cost, same-outcome care, not penalise it.

Inflation adjustment: Pay costs are deflated using national pay award uplifts; non-pay costs using CPI, RPI and GDP deflator. A trust that spent more because of a national pay settlement is not penalised for it. High-cost drugs, private patient income and redundancy costs are excluded.

Difference from ONS: The ONS also publishes NHS productivity figures, but it is a different measure. ONS quality-adjusts for waiting times, survival rates and patient outcomes, is published with a two-year lag, and covers UK-wide healthcare rather than acute trusts in England only. The two measures will give different answers for the same period, and that is expected. The 2% Spending Review target is tracked against this NHSE methodology, not ONS.

What it doesn't measure

This is not an outcomes measure. A hip replacement is counted the same regardless of the quality-of-life improvement it delivered. It does not capture prevention, population health, or the value of keeping people out of hospital, the very things the 10 Year Plan is built around. The methodology is transparent about these limitations.

Why this matters right now

The first estimates were published on 12 February 2026. For every board and executive team, the immediate task is understanding what their number means in context, how their activity mix, care model and cost reporting combine to produce it, and whether it reflects genuine improvement, deterioration or data artefacts.

The methodology is explicit that SDEC reporting changes, EPR implementations and unaudited monthly finance returns all create distortions at trust level. Estimates are provisional. Trusts can raise data notifications. The number is meant to be a starting point for a conversation, not a final verdict.

Source: NHS productivity growth estimate (2025/26) https://www.england.nhs.uk/long-read/nhs-productivity-growth-estimate-2025-26-methodology/