PUBLIC POLICY PROJECTS

INSIGHT • ANALYSIS • INTELLIGENCE

INSIGHTS

Beyond productivity: delivering high-quality, efficient healthcare

CHAIRED BY RT HON STEPHEN DORRELL

dr.foster FOUREYES INSIGHT PRISM IMPROVEMENT ARQIS HEALTH

Contents

Key Information

ABOUT PPP

Public Policy Projects (PPP) is an independent organisation operating at the heart of health and life sciences policy delivery. PPP brings together senior leaders and practitioners in the public and private health and life sciences sectors to find realistic solutions to the most pressing issues relating to health and care delivery.

ABOUT THIS REPORT

This report is based on a roundtable discussion held on Wednesday 10 June 2026 in Manchester. The discussion brought together senior NHS trust and system leaders, including executive, operational, quality, safety and improvement leaders.

The roundtable explored how the NHS can deliver high-performing, high-quality and efficient healthcare in a context of sustained operational and financial pressures.

The discussion was held under the Chatham House Rule and supported by Arqis Health. Arqis Health brings together Dr Foster, Four Eyes Insight and Prism Improvement to support NHS leaders with healthcare analytics, operational improvement and the sustaining of quality and productivity gains.

Quotations have been anonymised in line with the Chatham House Rule. PPP has supplemented the roundtable discussion with further policy analysis.

The discussion focused on how the NHS can move beyond a narrow interpretation of productivity and towards a broader understanding of value, one that aligns operational performance, safety, effectiveness, patient experience and population health outcomes.

Key Insights

- Productivity and quality must be treated as connected, not competing, objectives. Participants argued that safer care, better flow, reduced harm and improved patient experience are central to sustainable productivity.
- Boards need insight, not more data. Current reporting can create false assurance when it describes performance without helping leaders understand risk, variation or the action required.
- Length of stay should be understood as a quality issue. Long hospital stays can expose patients to avoidable harm, reduce independence and limit access for others.
- Improvement depends on the connection between analysis, action and sustainability. Data is valuable only when operational and clinical teams have the authority, relationships and capability to act on it.
- Predictive analytics must be matched by operational capacity. Identifying patients at risk of deterioration, falls, readmission or prolonged stay is only useful if teams can intervene earlier.
- Boards need stronger quality intelligence across safety, effectiveness and experience. Patient and staff insight should be treated as part of core intelligence data, not as anecdotal evidence separate from it.
- The neighbourhood model requires a wider understanding of quality. Trusts cannot improve flow and outcomes in isolation from community capacity, social care and population health.

Roundtable findings

INTRODUCTION: FROM PRODUCTIVITY TO VALUE

The NHS is under sustained pressure across urgent and emergency care, elective recovery and cancer performance. While productivity remains a central concern, participants argued that improvement cannot be achieved through activity measures alone. Productivity, quality and value must be understood together. Reducing avoidable waits, improving flow, preventing harm and using clinical capacity well are quality issues as much as performance issues.

This view aligns with Lord Darzi's independent investigation, which argued that access and quality sit at the heart of the NHS' relationship with the public.[1] Lord Darzi's report concluded that much NHS care remains high quality, but that performance has deteriorated across major services. It argues that quality should become the organising principle of the NHS. The government's 10-Year Health Plan reinforces this direction. It sets out a shift toward value-based care, where financial flows support innovation, best practice, community-based care and outcomes, rather than activity alone.[2]

However, participants noted a persistent tension in national policy, which increasingly speaks the language of quality and value, while boards remain under immediate pressure to deliver financial sustainability and operational recovery. The roundtable explored how NHS leaders can reconcile these demands by reconnecting three functions that are often treated separately: analysis, improvement and sustainability.

Delegates argues that data and analytics should not simply describe performance for assurance purposes. They should help leaders understand where care is falling short, where variation is unwarranted, and where improvement can be embedded.

Participants reflected that trust boards are under intense pressure to focus on finance, urgent and emergency care performance, referral to treatment times and other high-profile operational indicators. These metrics remain important, but the risk is that they crowd out a more holistic conversation about quality and value.

Several participants described board packs that contain large volumes of information but limited insight, making it difficult for executive and non-executive directors to identify the most important signals. NHS England's Insightful Provider Board guidance reinforces this point. It argues that boards need information that supports curiosity, challenge and problem-sensing, rather than simply receiving ever larger packs of performance data.[2]

The National Quality Strategy was seen as an opportunity to reset this conversation, particularly through its focus on safety, effectiveness and patient experience. However, participants cautioned that the NHS already has a great deal of data. What it must improve is how it interprets these data, how it connects them to clinical and operational action, and how it uses them to support strategic choices.

IMPROVEMENT IN PRACTICE: LEARNING FROM WYTHENSHAWE

A case study from Wythenshawe Hospital illustrated how quality improvement can create measurable operational gains when it is grounded in clinical leadership, multidisciplinary working and a clear understanding of the patient journey.

The work began from a position of significant pressure, including very long lengths of stay and patients waiting in corridors. Over an 18-month to two-year period, the team reduced the number of very long-stay patients substantially and reported an average length of stay reduction of four days. This local example reflects the direction of national reform, as NHS England's medium-term planning framework identifies reducing avoidable hospital bed-days for high-risk cohorts as a core priority.[4]

However, the improvement was not presented as a quick technical intervention. Instead, attendees described it as a structured quality improvement programme that combined senior oversight, ward-level engagement, real-time data and a cultural shift in how teams understood inpatient time.

MAKING INPATIENT TIME VISIBLE

A central feature of Wythenshawe Hospital's approach was a re-framed multidisciplinary meeting focused on complex patients and discharge barriers. Rather than functioning as a general discussion forum, the meeting used clearly defined criteria to identify patients requiring senior attention. Initially, the focus was on patients with very long stays and as improvement took hold, the threshold was progressively lowered. The ambition was to intervene earlier and prevent long stays from developing in the first place.

Participants highlighted several features that made the approach effective. Senior clinical, nursing, occupational therapy and discharge leadership were present in the room. Ward teams were expected to bring named patients and clear plans. Data from the electronic patient record supported automated identification of patients who met the criteria. Meeting outcomes were written back into the patient record, creating clear communication with the teams responsible for care.

DATA AS A ROUTE TO ACTION

The case study also demonstrated that data is only valuable when it can accurately inform practice. The automated list helped identify patients who needed attention, but the change depended on the people around the table having hte authority, relationships and shared purpose to act.

Participants noted that some of the most difficult barriers to discharge were not just clinical, but related to family expectations, community capacity, social care pathways and staff confidence in making decisions.

The discussion repeatedly returned to the idea of valuing patients' time.

Speakers linked long stays to patient experience, safety and effectiveness, alongside the pressure they place on bed capacity. Keeping people in hospital longer than clinically necessary can expose them to harm, reduce independence and prevent others from accessing care. Length of stay was therefore discussed as a measure of care quality, rather than a narrow operational target.

Participants argued that length of stay should be understood as a potential risk factor and a quality indicator. If patients remain in hospital when they no longer need medical care, this may indicate ineffective care, poor system flow, or inadequate community support.

RECOGNISING THE LIMITS OF HOSPITAL-ONLY IMPROVEMENT

The Wythenshawe example also showed the limits of hospital-only improvement. Participants emphasised that trusts sit within wider local systems, and that improvements in one pathway or geography can create pressure elsewhere if not understood systemically. Policy is moving in the same direction. As the 10-Year Health Plan describes a neighbourhood model designed to end fragmentation and provide more continuous and accessible care.[5]

> *"We are not islands of health care - it's not just about the regional and the national data sets, it's about actually what happens within the locality."*

Trusts can improve internal processes, but they cannot solve flow, discharge and quality challenges in isolation. Sustainable improvement depends on shared system responsibility and action.

IMPLICATIONS FOR BOARDS

BOARDS NEED INSIGHT, NOT MORE DATA

A major theme of the roundtable was the role of boards in creating the conditions for improvement. Participants considered whether boards have become too detached from quality and outcomes, and too focused on finance and core operational metrics. Views differed, but there was broad agreement that boards need better ways to see, interpret and act on quality intelligence.

One participant described the risk of "false assurance", where board reporting appears comprehensive but fails to expose the issues that most need attention. Benchmarking was seen as useful, but insufficient if it encourages organisations to take comfort from being no worse than others, rather than asking whether care is good enough.

The centre has sought to respond by introducing greater transparency through the NHS Oversight Framework. This brings together performance, patient safety, effectiveness and experience, workforce, finance and productivity measures, and publishes provider-level data to support accountability and improvement.[6]

However, participants argued that the design of national metrics still matters. If prevention, inequalities or population outcomes are treated as contextual rather than central to assessment, boards may still be incentivised to prioritise short-term operational recovery over longer-term value.

The distinction between assurance and reassurance is central. NHS England's guidance warns that boards need independent evidence, triangulation and a clear understanding of what has changed, not simply reassurance that an issue is being managed.[7]

Non-executive directors are seen as essential to quality governance, but participants questioned whether they are always equipped with the right information, training and framing. In areas such as maternity, for example, boards may receive mandated reports without always being clear which signals matter most, what poor outcomes mean for patients, or which questions should be asked of clinical leaders

> *"If we use maternity, for example, how many NEDs (non-executive directors) know what a third-degree tear is, let alone that it's a really poor outcome?"*

Maternity illustrates why boards need both data and interpretation. National policy is moving towards near-real-time safety signals, including the Maternity Outcomes Signal System.[8] However, the value of such tools depends on whether boards have the capability and culture to ask the right questions and act on what they reveal.

Several participants argued that the task is not to turn boards into technical committees, but to help them ask better questions. This requires reporting that connects data to the realities of care, including safety, effectiveness, experience, workforce and resource choices. It also requires executives to present information in a way that supports judgement, rather than overwhelming boards with volume.

FROM RETROSPECTIVE REPORTING TO PREDICTIVE INTELLIGENCE

Participants also discussed the need to move from retrospective reporting to predictive and problem-sensing intelligence. Data should help leaders anticipate which patients are at risk of falls, re-admission, deterioration or long lengths of stay, and enable operational teams to intervene earlier. However, several participants cautioned that predictive analytics would fail unless the organisation has the capacity and culture to act on the insight.

Predictive tools do not create improvement by themselves, they identify risk. The value comes when clinical and operational teams can respond. However, analytical capability was identified as a gap across multiple levels of the system. The challenge is not confined to boards – operational, clinical, and digital teams all need support to understand, own and use data. Without this, insight remains remote from the people who can change care.

NHS England's 2026 transparency update says that open data can strengthen accountability and improve quality, but it also warns that delivery is exposed to analytical capacity risks, including the possible loss of loss of up to a third of internal NHS England analysts through voluntary redundancy.

If current analytical capacity is under pressure, systems lose experienced analysts and are less able to turn data into useful intelligence. While national policy asks boards to make better use of data, local systems may have fewer people with the skills to support that work.

The value of predictive analytics will depend on whether systems have the analytical capacity, data quality and operational capability to act on the insights generated. National policy is increasingly pro-transparency, but implementation will require sustained investment – training staff as well as rolling out new platforms.

LEARNING FROM WHAT WORKS

The roundtable also emphasised the importance of learning from what goes well. NHS quality conversations often focus on the minority of cases where harm occurs, which is necessary, but insufficient. Participants argued for more rigorous learning from good practice, positive variation, and services that have found solutions others could adopt. This is a cultural and practical challenge. Systems need better mechanisms to identify effective practice, understand why it works, and scale it in different contexts.

Participants warned against assuming that success can simply be copied from one service to another. Improvement depends on local relationships, leadership, workforce confidence, data and operational context. However, they argued that the NHS should be more systematic in studying positive deviance. This means asking why some teams achieve better outcomes under similar constraints, and what others can learn from them.

PATIENT AND STAFF EXPERIENCE AS QUALITY INTELLIGENCE

Patient and staff experience were also seen as central to quality intelligence, not separate from it. Participants warned against treating "data" as hard evidence and patient experience as anecdote. Digital tools, patient feedback, board-to-ward visits and staff insight can all help boards understand whether care is working in practice.

> *"It's all about the story that comes with the data. Because if you put the data there in black and white, it's easy to misinterpret. It's not about that – it is about the experiences for patients and staff, that's how we drive up high-quality care."*

Current patient safety policy supports this view. The Patient Safety Incident Response Framework (PSIRF) places patient, family and staff involvement as crucial to learning from incidents. The 10-Year Health Plan also proposes wider use of patient-reported outcomes, patient-reported experience measures and patient ratings to inform choice and accountability.[10]

However, participants noted a live policy tension. While national reform seeks to give patient voice greater prominence, proposals to abolish Healthwatch raise questions about whether patient insight will remain sufficiently independent, local and trusted.[11]

Boards therefore need to consider how patient and staff insight is gathered, interpreted and acted on. Experience data should not sit in a separate part of the board pack. It should be triangulated with operational, safety, workforce and financial information.

This is particularly important where formal metrics look acceptable, but patients or staff describe a different reality. In those cases, experience data can help boards identify risks before they appear in performance indicators

CONCLUSION

The discussion concluded that delivering high-performing, high-quality and efficient healthcare requires a more mature understanding of value. Finance matters, but it must be held in context. Productivity matters, but it must be pursued through safer, more effective and more person-centred care. Data matters, but only when connected to story, leadership, culture and action.

The direction of national improvement policy supports this. NHS IMPACT frames continuous improvement as the means through which systems and organisations can respond to current pressures while delivering better care and outcomes. [12]

The policy direction is broadly aligned. The delivery question is whether boards and systems will have the time, analytical capacity, workforce, financial flexibility and improvement capability to turn that direction into sustained change.

The roundtable offered an optimistic message: improvement is possible, even under pressure. But will require boards to focus on the right questions, support clinical and operational teams with meaningful intelligence, and treat quality not as a parallel agenda to performance, but as the route to sustainable performance.

> *"The data becomes an end in and of itself unless it tells us what we are here to do."*

The central lesson is that the NHS cannot deliver sustainable productivity by treating quality, performance and finance as separate agendas. Boards need better insight, not more data. Improvement must connect analysis, action and sustainability across hospitals, neighbourhoods and wider systems.

References

1. Department of Health and Social Care (2025). Independent Investigation of the National Health Service in England. Available from: https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england/independent-investigation-of-the-national-health-service-in-england-accessible-version
2. Department of Health and Social Care (2025). Fit for the future: 10 Year Health Plan for England. Available from: https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future/fit-for-the-future-10-year-health-plan-for-england-executive-summary
3. NHS England (2024). The insightful provider board. Available from: https://www.england.nhs.uk/long-read/the-insightful-provider-board/
4. NHS England (2026). 1 April 2026 next steps on planning and priorities for 2026/27. Available from: https://www.england.nhs.uk/long-read/1-april-2026-next-steps-on-planning-and-priorities-for-2026-27/
5. Department of Health and Social Care (2025). Fit for the future: 10 Year Health Plan for England. Available from: https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future/fit-for-the-future-10-year-health-plan-for-england-executive-summary
6. NHS England (2025). NHS Oversight Framework 2025/26. Available from: https://www.england.nhs.uk/long-read/nhs-oversight-framework-2025-26/
7. NHS England (2024). The insightful provider board. Available from: https://www.england.nhs.uk/long-read/the-insightful-provider-board/
8. NHS England (2025). Medium Term Planning Framework – delivering change together 2026/27 to 2028/29. Available from: https://www.england.nhs.uk/long-read/medium-term-planning-framework-delivering-change-together-2026-27-to-2028-29/
9. NHS England (2026). A new era of transparency – progress update. Available from: https://www.england.nhs.uk/long-read/a-new-era-of-transparency-progress-update/
10. NHS England. Patient Safety Incident Response Framework. Available from: https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/
11. Department of Health and Social Care (2026). Health Bill: impact assessments summary. Available from: https://www.gov.uk/government/publications/health-bill-impact-assessments-summary/health-bill-impact-assessments-summary
12. NHS England. NHS IMPACT. Available from: https://www.england.nhs.uk/nhsimpact/

Attendees

Rt Hon Stephen Dorrell
Chair, Public Policy Projects

Jenny Beynon
Clinical Head of Medicine, Wythenshawe, Trafford, Withington & Altrincham Hospitals

Alex Kafetz
Non-Executive Director, Care Quality Commission and Adviser, Arqis Health

Stephanie Lawton
Chief Executive Officer, Manchester Royal Infirmary Clinical Group

Sam Goldberg
Executive Director of Commissioning – Acute & Adult Mental Health Services, NHS Essex Integrated Care Board

Charlotte Williams
Deputy Chief Executive, North West Anglia NHS Foundation Trust

Parya Rostami
Head of Quality Improvement, Sheffield Health Partnership University NHS Foundation NHS Trust

Anne Eden
Regional Director, South East, NHS England

Ailsa Brotherton
Chief Strategy and Improvement Officer, Lancashire Teaching Hospitals NHS Foundation Trust

Helen Skinner
Chief Medical Officer, University Hospitals Of Morecambe Bay NHS Foundation Trust

Chris Evans
Deputy Chief Executive Officer, Mid Yorkshire Teaching NHS Trust

Russell Nightingale
Chief Delivery Officer, University Hospitals Tees

Timothy Ho
Chief Medical Officer, Frimley Health NHS Foundation Trust

Kudzai Mika
Head of Quality Governance, King's College Hospital NHS Foundation Trust

Frances Woodroffe
Interim Deputy Chief Executive, Medway NHS Foundation Trust

Kate Shields
Chief Executive Officer + Chief Executive Designate, NHS Kernow + Cornwall and Isles of Scilly Integrated Health Board

Huw Edwards
Deputy Chief Delivery Officer, University Hospitals Sussex NHS Foundation Trust

Jenny Lewis
Chief Executive Officer, Dr Foster, Arqis Health

Jez Tozer
Chief Executive Officer, Prism Improvement and Four Eyes Insight

Peter Fry
Managing Director, Prism Improvement

Lee Scothern
Managing Director, Four Eyes Insight