NHS England

Annual Report and Accounts 2024/25

For the year ended
31 March 2025

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For the period 1 April 2024 to 31 March 2025

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Foreword: A view from Dr Penny Dash, Chair

I am honoured to have been appointed the new Chair of NHS England at a vital moment for our health service, one that requires a sustained programme of reform to ensure an NHS fit for the future.

The challenges before us are significant. With more and more people living with long term conditions and in poor health, continued unacceptable variation in quality of care and 7.6 million people waiting for treatment and public satisfaction at record lows, the case has never been stronger. Yet within these challenges lies an opportunity to reimagine healthcare for generations to come.

I am particularly energised by the three transformative shifts at the heart of our 10-Year Health Plan: moving care from hospital to community, transitioning from analogue to digital systems, and shifting our focus from sickness to prevention. These changes are not merely aspirational - they are essential to the very survival of our health service.

The recent Spending Review announcement demonstrates the government's commitment, with £29 billion additional annual funding by 2028/29. However, as someone who has worked in healthcare for many years, I know that investment must be paired with meaningful reform to truly deliver for patients and communities.

I want to acknowledge the dedication and professionalism of our NHS England staff during this period of significant change. As neither Jim nor I were in post during the reporting period, I particularly want to thank the previous senior leadership team who provided exemplary service throughout this time. The planned organisational integration with the Department of Health and Social Care (DHSC) in no way reflects on the talent, expertise and commitment amongst our workforce.

I've been deeply impressed by the resilience shown by colleagues who have continued to drive improvements in patient care while facing uncertainty about their future. Their unwavering focus on what matters most, the health and wellbeing of the nation, demonstrates the very best of public service values.

The 10-Year Health Plan represents a once-in-a-generation opportunity to shape the NHS in order to improve health, access to care and address the persistent health inequalities that continue to plague our society. I look forward to playing my part in this vital mission, ensuring our NHS continues to serve the needs of its patients and wider communities while remaining true to its founding principles.

Dr Penny Dash
Chair, NHS England

Performance report

Sir James Mackey, Accounting Officer

21 October 2025

Chief Executive’s overview

The past year has marked a pivotal moment for our National Health Service. Following the Spending Review and with the publication of our 10-Year Plan, we have begun to lay the foundations for a fundamental transformation of healthcare in this country.

The NHS has secured significant investment – £29 billion additional annual funding by 2028/29, alongside record capital investment and £10 billion for digital transformation. Nevertheless, we recognise that investment alone cannot solve the challenges we face. The public's satisfaction with the NHS is at a record low, and we must rebuild that essential bond of trust.

Our transformation is built on three fundamental shifts that will reshape healthcare delivery. We are moving from hospital to community by creating a new neighbourhood health service that brings care closer to people's homes. We are transitioning from analogue to digital by modernising our systems to harness technology and improve patient experience, and, we are shifting focus from sickness to prevention, concentrating on keeping people well rather than simply treating illness.

To deliver these changes, we are resetting how we work together across the system. We're moving away from over-prescription and centrally mandated processes, instead focusing on outcomes rather than inputs. We are creating conditions where local leaders have greater autonomy to meet the specific needs of their communities, while still delivering against clear national priorities.

We have already made important progress, with improvements demonstrated across virtually every performance measure over the last year, despite the challenges posed by industrial action. We have delivered 3.6 million more appointments than last year and diagnosed an additional 187,000 suspected cancer patients within 28 days. Our aim to meet the NHS standard of 92% of patients waiting no longer than 18 weeks for treatment is ambitious but achievable.

These are challenging times, but they also present an extraordinary opportunity to reimagine healthcare. By working together – trusting local leadership, releasing ambition, and embracing innovation – we can ensure the NHS not only survives but thrives for generations to come.

The NHS belongs to us all. It's our collective responsibility to protect and transform it. I am confident that together we can build an NHS that delivers better care for patients and better value for taxpayers.

Finally, I want to acknowledge the talent and commitment of our NHS England staff across the Country. The coming months will be tough as we navigate organisational changes and heightened expectations. I have met many staff over these first few months in post and seen firsthand their resilience and dedication to making a difference for patients and the NHS. It's this spirit that gives me absolute confidence that, together, we can rise to the challenges ahead and deliver the transformation our NHS needs.

Sir James Mackey
Chief Executive

Performance overview

Summary

The performance overview section provides a clear and accessible summary of performance during 2024/25. It sets the context for the detailed financial and governance disclosures that follow and helps users of the report understand:

- who we are and what we do, including our mission, values and role within the wider health and care system
- how we've performed, highlighting progress against strategic objectives and setting out major achievements and areas for improvement
- why it matters, reinforcing our commitment to transparency, accountability, and continuous improvement in delivering high-quality care for patients and communities.

More detailed performance information, along with additional context, is contained within the performance analysis, from page 18.

About NHS England

NHS England leads the National Health Service in England, sharing with the Secretary of State for Health and Social Care the legal duty to promote a comprehensive health service, in accordance with the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022).

Our vision is high quality healthcare for all, and our mission is to:

- drive the delivery of safe and high-quality care in the right place and at the right time for patients
- support NHS staff with the training, data and tools they need to provide the best possible care
- deliver value for money for taxpayers, supporting the health of the population and the wider economy.

Our structure

NHS England is governed by a unitary Board which is accountable to the Government, Parliament and the public. Our Chief Executive Officer, Sir James Mackey, is accountable to Parliament and the Secretary of State for Health and Social Care.

We operate through seven regional teams working directly with systems and NHS providers across the country. Most services are commissioned by Integrated Care Boards (ICBs), which lead 42 local Integrated Care Systems (ICSs) comprising NHS organisations, primary care professionals, local councils, social care providers and community partners.

Organisational changes

In March 2025, the Prime Minister announced significant structural changes affecting the DHSC and NHS England. The government confirmed that NHS England will be abolished with its functions being integrated into the Department. These changes are subject to primary legislation, which will be implemented subject to agreement by parliament.

As part of these changes, the combined headcount across both organisations is expected to reduce by approximately 50 per cent. The objectives for this integration include: reducing administrative processes; eliminating operational duplication; and reallocating resources to support increased frontline clinical staff, including nurses, doctors, and other healthcare professionals.

The changes represent a significant shift in the governance and operational structure of health services administration in England.

Our responsibilities

NHS England allocates £151 billion of funding to local NHS systems and sets the priorities to deliver high quality care and value for taxpayers. We:

- oversee the delivery of safe and effective services across nearly 7,000 NHS organisations
- drive best practice, improvement and innovation through initiatives such as NHS IMPACT (Improving Patient Care Together)
- plan, recruit, educate and train the NHS workforce, providing digital learning platforms used by 3.5 million staff
- use health data to transform services, supporting research and innovation
- negotiate deals for vital products and services, delivering significant efficiency savings
- deliver digital services at scale, including the NHS App (used by 36 million people) and NHS 111 online.

Our history

On 1 April 2023, NHS England incorporated Health Education England, completing the formation of the new NHS England which had previously merged with NHS Digital on 1 February 2023. This streamlining reduced our overall headcount by over 35% and provided nearly £500 million of savings to support frontline services.

Our work is also supported by third party organisations including NHS Business Services Authority, NHS Shared Business Services, NHS Property Services Limited and Primary Care Support England provided by Capita.

Our aims

The NHS England Operating Framework sets out six aims:

- longer healthy life expectancy
- excellent quality, safety and outcomes
- excellent access and experience
- equity of healthy life expectancy, quality, safety, outcomes, access and experience
- value for taxpayers' money
- support to society, the economy and environment.

How we measure performance

The NHS Constitution sets out the rights of patients, the public and staff. We measure and monitor NHS provider and system/ ICB performance against a wide range of constitutional performance standards and publish statistics relating to these core constitutional standards on the NHS England website every month.[1]

ICB performance

In line with its statutory obligations, NHS England assessed each ICB performance covering the 2024/25 financial year and will publish a summary of each assessment on our website later in 2025. In line with the NHS oversight framework, all ICBs were placed into one of four support segments. At the end of 2024/25 NHS England was providing intensive support via the Recovery Support Programme to four ICBs. During the reporting period, one ICB entered the programme and none left it.

NHS England can use statutory enforcement powers where an ICB is failing, or is at risk of failing, to discharge any of its functions. During 2024/25 no formal legal directions were issued, however NHS England accepted new enforcement undertakings from six ICBs. These were in addition to the existing undertakings in place with NHS Hampshire and Isle of Wight ICB, which were applied in 2023/24 and remain in place. Copies of these undertakings are publicly available on the NHS England website.[2]

Trust performance

During 2024/25, five trusts entered the Recovery Support Programme[3], with three trusts exiting and one being dissolved as part of an organisational acquisition. There was a small increase in the number of trusts (two providers) in segment four at the end of the reporting period, compared with the same point in the previous year.

There were no instances of NHS England issuing new legal directions this year. Seven trusts agreed new undertakings and a further nine saw existing undertakings superseded by revised measures. Nine trusts had existing undertakings lifted, either due to compliance or discontinuation, leaving 43 trusts with undertakings at year-end (44 in 2023/24).

ICB and provider annual reports

2024/25 ICB annual reports and accounts were published on their individual websites, links to these can be found on our website.[4]

All NHS trusts and NHS foundation trusts (‘providers’) in England publish an annual report and accounts on their individual websites. The results of all providers are published by NHS England in Consolidated Provider Accounts.[5] These are presented separately from those of NHS England, as NHS England is not the parent body of providers.

[1] https://www.england.nhs.uk/statistics/statistical-work-areas/
[2] https://www.england.nhs.uk/publication/nhs-integrated-care-board-directory/
[3] https://www.england.nhs.uk/system-and-organisational-oversight/national-recovery-support-programme/
[4] https://www.england.nhs.uk/integratedcare/integrated-care-in-your-area/more-about-each-integrated-care-system/
[5] https://www.england.nhs.uk/?s=Consolidated+Provider+Accounts

Overview of 2024/25 operational performance

As detailed in the 2024/25 Operational Planning Guidance, our overall priorities remained:

- Quality and patient safety
- Recover our core services
- Transform the way we deliver care and create stronger foundations for the future.

Against the backdrop of rising costs, unprecedented industrial action, and longer-term underinvestment in capacity, NHS productivity continued to improve. During 2024/25 the acute sector improved its implied productivity by 2.7%, doubling the pre-pandemic rate. This is a measure of how efficiently the NHS uses its resources by comparing increases in activity (outputs) to increases in costs, adjusted for inflation and is calculated using a cost weighted activity method. However, progress against the core performance priorities we set out has been limited. Whilst more people are receiving treatment in A&E within four hours, a growing number have also been waiting longer. In elective care and in primary, community and mental health services, despite seeing record numbers of patients, continued high demand means patients continue to experience difficulty accessing services.

In Urgent and Emergency Care (UEC) our headline objectives were to improve ambulance response times and A&E waiting times. Despite record numbers of patients being seen, and improvements made compared to the previous year, ambitions to reduce average category 2 ambulance response times to 30 minutes and to ensure at least 78% of patients attending A&E were seen within four hours by March 2025 were not met.[6] This is due to several factors, such attendances at Emergency Departments rising by 4.0% in 2024/25 compared to 2023/24 and ambulance incidents increasing by 4.6% in 2024/25. Although the percentage of conveyed patients only rose by 1.6%. The impact of flu pressures was different to 2023/24, and the number of beds occupied peaked higher than previously with almost 5,600 in early January 2025 (January 2024: 2,500). Moreover, difficulties in discharging medically fit patients, to reduce bed occupancy and acute length of stay, provided a challenging environment for UEC services in 2024/25).[7]

For Primary Care and Community Services, operational performance has been challenged against a backdrop of increasing demand for primary care and community services and GP collective action. The NHS saw improvements in experience of access to general practice, including same day appointments, but there remains variation at local level. However, the NHS did not meet objectives on improving community service waiting times or increasing units of dental activity (UDA) to pre-pandemic levels.

In elective care, we are delivering more diagnostic tests and treating more patients. We have outperformed the system specific activity targets, consistent with the national value weighted activity target of 107% with February 2025 showing performance at 121.5%. The NHS made significant progress in reducing long waits for elective care during 2024/25, but it did not fully meet the national target of eliminating waits of over 65 weeks for consultant-led elective

[6] https://www.england.nhs.uk/long-read/delivery-plan-for-recovering-urgent-and-emergency-care-services-january-2023/
[7] https://www.gov.uk/government/statistics/national-flu-and-covid-19-surveillance-reports-2024-to-2025-season

treatment by September 2024. In January we published our Elective Reform Plan which sets out how the NHS will reform elective care services and meet the 18-week referral to treatment standard by March 2029.

The NHS exceeded its cancer targets by the end of March 2025. The Faster Diagnosis Standard performance was 78.9% (target 77%), and the 62-day performance was 71.4% (target 70%).

Progress continued against aspects of our maternity delivery plan, with reductions in the rate of brain injury and rates of stillbirth, neonatal death and maternal mortality largely remaining stable. Inequalities in outcomes persist, with women and babies from Black and Asian and the most deprived backgrounds being more likely to experience adverse outcomes.

There were more midwives at the end of the reporting period, with 26,835 whole time equivalents (WTE) in post (1,700 WTE more than March 2024). This comes alongside a sustained decline in leaver and turnover rates.

Performance analysis

In this section, we provide detail on the work we have delivered during the year. These key areas of performance relate closely to the objectives set out in our annual business plan and reflect progress made against the aims set out in the Government's mandate to the NHS.

For more detail on how we delivered against the mandate, see page 178.

Key performance indicators

Programme work area	Ambition	Performance
Urgent and emergency care		
Improvement of A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025	78%	75.0%
Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25	30 minutes	35 minutes 22 seconds[8]
Cancer		
Improve performance against the headline 62-day standard by March 2025	70%	71.4%
Improve performance against the 28-day Faster Diagnosis Standard	77% by March 2025	78.9%
Increase the percentage of cancers diagnosed at stages 1 and 2	75% by 2028	60% (March 2025)
Diagnostics		
Increase the percentage of patients that receive a diagnostic test within six weeks	95% by March 2025	81.6%
Elective Care		
Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest	Virtual elimination	22,884 (September 2024) 7,380 (March 2025)
Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%	107%	121.8% (March 2025)
Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25	46%	45.5% (March 2025)
Primary and Community Care		
Improve community services waiting times, with a focus on reducing long waits for children and young people	N/A	67,725 waits over 52 weeks

[8] mean ambulance response time for 2024/25

Programme work area	Ambition	Performance
Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving UDA towards pre-pandemic levels	N/A	82%
Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are accessed the same or next day according to clinical need	2023/24 baseline	82.1%
Mental Health		
Increase the number of people accessing transformed models of adult community mental health (to 400,000), perinatal mental health (to 66,000) and children and young people services (345,000 additional CYP aged 0–25 compared to 2019)	400,000	597,374
	660,000	63,784
	840,254	829,308
Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement and 48% reliable recovery	700,000	667,143
Reduce inequalities by working towards 75% of people with severe mental illness (SMI) receiving a full annual physical health check, with at least 60% receiving one by March 2025	60%	66.5%
Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2025	66.7%	65.6%
People with a learning disability and autistic people		
Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025	75%	79.88%
Prevention and health inequalities		
Increase the % of patients with hypertension treated according to National Institute for Health and Care Excellence (NICE) guidance to 80% by March 2025	80%	70.3%
Increase the percentage of patients aged 25–84 years with a cardiovascular disease (CVD) risk score greater than 20% on lipid lowering therapies to 65% by March 2025	65%	63.6%
Use of resources		
Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25	<3.2%	2.3%

Quality

All NHS organisations have responsibility for the quality of services, and both ICBs and NHS England have a statutory duty to act with a view to securing continuous improvement in quality.

Patient safety

The NHS Patient Safety Strategy is now in its sixth year and continues to deliver its aims, saving an extra 1,000 lives and £100 million in care costs per year from 2024.[9]

An estimated 1,500 neonatal lives have been saved through safer care bundle interventions, and 1,900 deaths prevented through the medicine's safety improvement programme, which has also avoided hundreds of millions in care costs.

In May 2024, NHS England announced the testing and implementation of Martha's Rule in 143 pilot sites[10], empowering patients, families, carers and staff to ensure that their concerns are listened to and acted upon. Martha's Rule is creating a structured way for patients to provide daily updates on their condition and access to an urgent review if their or their loved one's condition deteriorates, and they are concerned this is not being responded to. In the first six months of implementation, 47% of the 2,389 calls related to acute deterioration; of these 1,298 calls resulted in potentially life-saving escalations of care, of which around a third led to a change in management or treatment.

In 2024/25, we completed the transition of all trusts to real time reporting via the Learn from Patient Safety Events service. This major upgrade made data (and analysis) relating to patient safety events available to all care settings. Around 3 million patient safety incidents were reported during the reporting period, allowing NHS England to identify risks that can be acted on, through National Patient Safety Alerts and collaborating with partners to address safety issues.[11] This work saves an estimated 160 lives per year and an estimated £13.5 million in additional treatment costs.

By September 2024, we completed the transition of all trusts to the Patient Safety Incident Response Framework[12], that required a complete overhaul of how NHS providers respond to patient safety incidents, emphasising the health system's focus on learning for improvement.

The NHS Patient Safety Syllabus[13] is building knowledge, capability and capacity in patient safety through the creation of the first system-wide standardised approach to patient safety training and education. Level 1 and level 2 training is available as e-learning to all NHS staff. Around 1.5 million staff completed level 1 training, including over 70,000 completions by Board members and senior leadership teams and over 850,000 completions for level 2 training by end of 2024/25. In addition to this around 500 staff completed level 3 and 4 training in 2024/25.

[9] https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/nhs-patient-safety-strategy-progress-so-far/
[10] https://www.england.nhs.uk/2024/05/nhs-announces-143-hospitals-to-roll-out-marthas-rule/
[11] https://www.england.nhs.uk/patient-safety/patient-safety-insight/patient-safety-alerts/#national-patient-safety-alerts
[12] https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/
[13] https://www.e-lfh.org.uk/programmes/patient-safety-syllabus-training/

NHS IMPACT

NHS IMPACT was introduced to help systems and organisations align improvement approaches by focussing on the most common components of improvement methodologies. This allows systems and organisations to use a shared improvement approach and apply this to the biggest challenges and opportunities they are facing.

NHS leaders have worked with their boards to understand how deeply improvement is embedded in their organisation. This has enabled the formulation of an improvement development plan to demonstrate progress against the self-assessment which organisations have completed.

A suite of resources was shared on the NHS IMPACT website to support organisations to build capability and capacity, including across system partners. Additionally, a series of activities ran throughout 2024/25, to support NHS staff to learn and adopt improvement methods and tools.

NHS IMPACT have established several key improvement networks, to bring together peers from different parts of the NHS to work together on key challenges and issues. To strengthen learning in key priority areas, improvement guides were made available in outpatients, UEC, theatre utilisation and job planning, along with the establishment of learning and improvement networks.

As part of the Clinical and Operational Excellence programme[14], learning and improvement networks brought peers together to focus on the development of data-enabled improvements. Led by 14 acute provider chief executives, these networks collaborate to deliver improvement programmes to improve patient flow, safety and productivity.

Developments have been made to the Model Health System to include analysis related to outpatients, theatres, and UEC improvement.

Insightful Board

Effective NHS boards need to be curious and continually looking to improve how they use the information they receive across all aspects of their organisation's operations. To support this and to help trust and ICB boards identify the information they need to manage their organisations effectively, in November 2024 NHS England published The Insightful Provider Board[15] and The Insightful ICB Board.[16] Built around six domains linked to capability and organisational priorities, these documents describe approaches to help boards ensure the right behaviours and culture are in place to use data effectively and drive improvement.

[14] https://www.england.nhs.uk/long-read/nhs-impact-learning-and-improvement-networks-and-improvement-analytics-and-working-guides/
[15] https://www.england.nhs.uk/long-read/the-insightful-provider-board/
[16] https://www.england.nhs.uk/long-read/the-insightful-icb-board/

Recovering our core services

Urgent and emergency care

We set two national NHS objectives for UEC in 2024/25, focused on a national priority to improve A&E waiting times and ambulance response times. These priorities were two-year ambitions outlined in the delivery plan for recovering urgent and emergency services, published in January 2023.[17]

The first national objective was to improve A&E waiting times by March 2025. 75.0% (target: 78%) of patients were admitted, transferred or discharged within 4 hours (74.3% March 2024).[18] Though the 78% ambition has not been achieved, the NHS did see a record 27.4 million number of patients with 20.2 million seen within 4 hours, an 8.4% increase compared to 2023/24. Performance falls short of the constitutional standard of 95%.

The second national objective for UEC was to improve Category 2 ambulance response times. The mean ambulance response time for 2024/25 was 35 minutes 22 seconds (target, 30 minutes).[19] Despite this being an improvement on the previous year (2023/24: 36 minutes, 23 seconds), the 2024/25 ambition and the NHS constitutional standard of 18 minutes[20] were not met.

Primary and community services

Primary care and community services had three national NHS objectives for 2024/25:

1. Make it easier for people to access primary care and community health services, particularly general practice and dentistry.
2. Improve timely access to primary care, as outlined in the delivery plan for recovering access to primary care (published in May 2023).[21]
3. Recover and reform NHS dentistry.[22]

Implementation of the second year of the Delivery Plan for Recovery of Primary Care has driven improvements to patient access to primary care. Pharmacy First was launched in January 2024 and during 2024/25 2.42 million clinical consultations were delivered by community pharmacy for common conditions. Additionally, there have been 407,329 oral contraception consultations and 3.1 million blood pressure checks conducted by community pharmacies, saving additional capacity in general practice.

By the end of the reporting period, 99.9% of practices had digital telephony in place and more than 700 practices were supported through the Practice Level Support programme, to better manage capacity and demand.

[17] https://www.england.nhs.uk/publication/delivery-plan-for-recovering-urgent-and-emergency-care-services/
[18] https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/
[19] https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/
[20] https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england/the-handbook-to-the-nhs-constitution-for-england
[21] https://www.england.nhs.uk/wp-content/uploads/2023/05/PRN00283-delivery-plan-for-recovering-access-to-primary-care-may-2023.pdf
[22] https://www.gov.uk/government/publications/our-plan-to-recover-and-reform-nhs-dentistry/faster-simpler-and-fairer-our-plan-to-recover-and-reform-nhs-dentistry

Since October 2024, over 1,000 additional GPs have been recruited by Primary Care Networks, through the Additional Roles Reimbursement Scheme. Supported by this work, 44.2% of general practice patients were seen on same day and 82.1% within two weeks in March 2025. The number of appointments offered in general practice, including COVID-19 vaccinations, increased by 3.69% with 383.4 million appointments offered by March 2025 (previous year: 369.8 million).[23]

The Health Insight Survey, launched in July 2024, showed how the improvements in access are benefiting patients and their experience of general practice. In March 2025, 72.9% of respondents reported that they found it easy to contact their general practice, (July 2024 when the survey was launched: 60.9%). The percentage of respondents who knew how their request would be managed on the same day as contacting their GP practice was 71.5% in March 2025 (July 2024: 70.3%).

Demand for community services has continued to grow in 2024/25, with an additional 1.75 million referrals to community services recorded during the reporting, compared to the previous year. To meet that demand, there were an additional five million consultations.[24] Despite the increase in capacity, the objective to improve community services waiting times - focusing on reducing long waits - has not been met and by March 2025, community service waits of over 52 weeks had increased to 77,712 (March 2024: 40,904). Adult waits of over 52 weeks saw a slight increase to 9,987 in March 2025 (March 2024: 9,208), however waits for children and young people rose markedly to 67,725 in March 2025 (March 2024: 31,696)[25], an increase driven primarily by rising demand for neurodevelopmental assessments. The increase across all community waiting times was driven by workforce shortages, skill mix limitations, commissioning and contracting issues and inconsistencies in clinical pathways.

The ambition to increase units UDA towards pre-pandemic levels, in March 2025, 82% of contracted UDA had been delivered across 2024/25.

Elective care

We set four national NHS objectives for elective care in 2024/25; all focused on the national priority to improve patient outcomes and experiences by continuing to reduce long waits for elective care.

The 2024/25 priorities and operational planning guidance included an objective to eliminate waits longer than 65 weeks, from consultant-led referral through to elective care treatment, by September 2024 (except where patients choose to wait longer or in specific specialties).

Despite a steady decline in long waits throughout 2024/25[26], the NHS did not achieve this. However, by March 2025, the number of patients waiting over 65 weeks had fallen to 7,381, a reduction of 84.9% (March 2024: 48,967).

[23] https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/january-2025
[24] https://digital.nhs.uk/data-and-information/publications/statistical/community-services-statistics-for-children-young-people-and-adults
[25] https://www.england.nhs.uk/statistics/statistical-work-areas/community-health-services-waiting-lists/
[26] https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2024-25/

These long waits now account for less than 0.1% of the total national waiting list. Ongoing surveillance of long waits is continuing in 2025/26, with a national priority for reducing the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026.

The second objective, relating to delivery of more routine elective treatment, on a value-weighted basis, was exceeded. By March 2025, year to date performance was at 121.8% against the 2024/25 annual target of 107%. A number of factors can influence the level of value-weighted activity including the types of activity delivered and the complexity of patients being treated. The NHS delivered more outpatient attendances and inpatient spells across 2024/25, with inpatient activity in particular driving value-weighted activity increases in part due to case mix complexity.

The third objective aimed to increase the proportion of all outpatient attendances for first or follow-up appointments that attract a procedure tariff (a set of prices for different healthcare activities) to 46% in 2024/25. Across 2024/25, cumulative performance was at 45.4% and 0.6ppt away from the ambition.

The fourth objective focused on enhancing patients' experience of choice at the point of referral into an elective care treatment pathway. As of the end of March 2025, 24.7% of respondents to the Health Insight Survey reported being offered a choice of hospital when referred by their general practice within the previous 28 days. This figure shows no change from the baseline recorded when data collection began in July 2024.

The plan for elective care reform was published in January 2025 by the DHSC and NHS England. The plan set out how the NHS will reform elective care services and meet the 18-week referral to treatment standard by March 2029. Ambitions include making elective care increasingly personalised and digital, with a focus on improving experience and convenience, and empowering people with choice and control over when and where they will be treated. The plan includes a range of initiatives and milestone dates which have been included as a way of reaching the ambition by the deadline.

Alongside the publication of the Elective Reform Plan, the NHS and the Independent Healthcare Provider Network established a partnership agreement, the first of its kind for 25 years, outlining plans to work together to reduce the elective waiting list. The NHS and independent sector will work together to encourage long-term relationships and continue to drive patient choice of providers. The independent sector will also aid the elective workforce's growth, provide training opportunities and offer greater support in the most challenged specialities such as ear, nose and throat, and gynaecology.

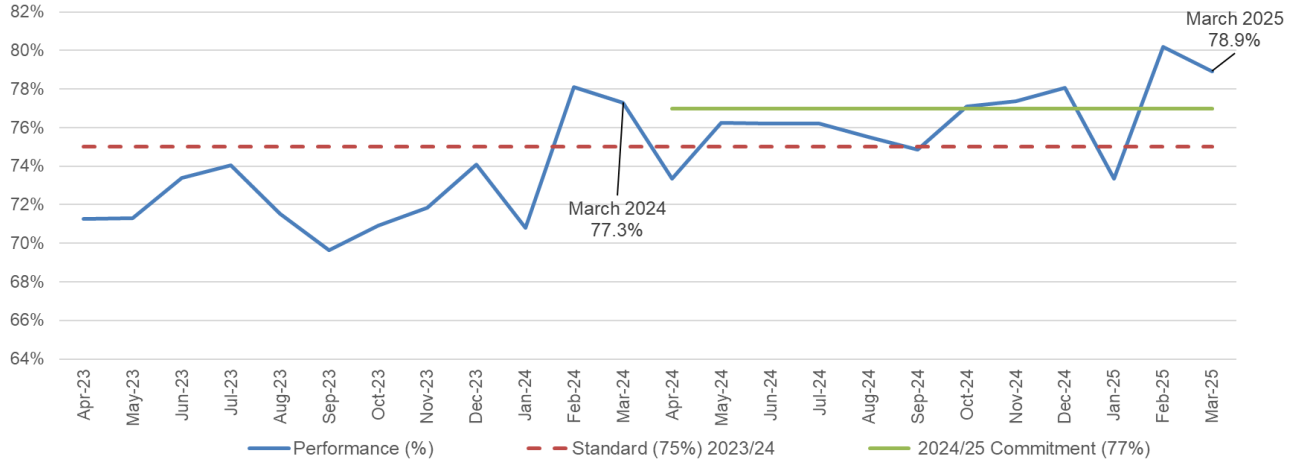
Cancer

The NHS delivered and exceeded its cancer targets by the end of March 2025, ensuring that:

- at least 77% of people receive a definitive diagnosis or ruling out of cancer within 28 days of an urgent referral (Faster Diagnosis Standard performance was at 78.9% in March 2025).
- at least 70% of people receive a first treatment within two months of referral or consultant upgrade (62-day performance was at 71.4% in March 2025).

NHS England provided targeted intervention and support to the most challenged providers. For performance against the 62-day standard, in the most challenged providers there was a 6.8%-point improvement between quarter 4 2023/24 and quarter 4 2024/25, compared to just 2.3% points in providers who were not in receipt of intervention. This approach has reduced variation across the country, with a system-level performance interquartile range of 8.5% points by March 2025 (March 2024: 9.3% points).

28 Day Faster Diagnosis Standard performance 2023/24 to 2024/25



We have also seen benefits from the implementation of key pathway changes. In quarter 4 2024/25, 41% of skin cancer referrals used a tele-dermatology approach in which high quality images are reviewed remotely, and through which most patients can be reassured and discharged. The implementation of faecal immunochemical testing (FIT) into the bowel cancer pathway has reached the target of 80% of referrals being accompanied by a FIT result, supporting an improvement in the Faster Diagnosis Standard performance for bowel cancer from 51% to 64.4% between quarter 3 2022/23 and quarter 3 2024/25.

The NHS cancer early diagnosis strategy aims to give patients a better chance of survival.[27] The early diagnosis rate has increased by 3.0% points since 2019, including a 1.4% improvement in the 12 months to March 2025, translating to 8,500 more people diagnosed early compared to 2019.[28]

[27] https://www.england.nhs.uk/long-read/cancer-programme-update/
[28] https://digital.nhs.uk/ndrs/data/data-outputs/cancer-data-hub/rapid-cancer-registration-data-dashboards

Diagnostics

Timely access to diagnostics was described in the 2024/25 priorities and operational planning guidance as vital for supporting elective recovery and early cancer diagnosis. We therefore set an objective for diagnostics, to increase the percentage of patients that receive a diagnostic test within six weeks, in line with the March 2025 ambition of 95%.

In March 2025, 81.6% of patients received a diagnostics test within six weeks, which is 13.4% below the ambition. However, progress has been made during 2024/25, with an increase from 78% in March 2024, building on gains made after pandemic restrictions were lifted.

The median average waiting time for a diagnostic test dropped to 2.74 weeks in March 2025 (March 2024: 2.9 weeks). This is a significant improvement on pandemic wait times (May 2020: 8.6 weeks) and is almost back to the pre-pandemic average (2019/20: 2.2 weeks) and means that patients are being diagnosed faster, leading to quicker treatment and better outcomes.

The NHS has delivered record levels of diagnostic activity in 2024/25, with every month seeing a new NHS monthly record for diagnostic activity – i.e., diagnostic activity in May 2024 was higher than any previous May. In 2024/25 an average of 2.4 million tests were carried out each month, delivering an 8% increase against the previous year and a 25% increase on pre-pandemic levels (2019/20). In March 2025, almost 2.5 million tests were performed in the 15 key diagnostic modalities[29], an increase of 9% (March 2023: 2.3 million tests).[30]

Community Diagnostic Centres (CDCs) delivered 6.8 million additional tests in 2024/25, including CT scans, ultrasound investigations, plain film x-rays and pathology tests.

Other investments in endoscopy and imaging capacity resulted in 450,000 other forms of medical imaging and 275,000 additional endoscopies.

The digitisation of diagnostic pathways has resulted in more rapid test acquisition, processing and reporting, which in turn has returned the following benefits:

- Improvement in productivity and improved staff satisfaction.
- Where consultant radiologists and reporting radiographers are using home reporting digital infrastructure for imaging reporting, the clinicians have reported a 9% increase in imaging reporting, working remotely.
- Where trusts have installed MRI acceleration software on MRI scanners, the associated scanners are seeing an average 14% increase in scanning throughput.
- Where trusts have deployed the iRefer clinical decision support tool at referring sites such as general practices and hospital departments, unwarranted test requests for CT, MRI and x-ray were reduced and 5% of imaging test requests were withdrawn by referring clinicians.
- The use of image sharing solutions within imaging networks is expected to reduce unwarranted repeat tests by up to 9%, based on the analysis of test requests for one imaging network.

[29] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/diagnostics-waiting-times-and-activity-dm01
[30] https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/

To mitigate the risk of performance targets not being met, NHS England supports systems to maximise the impact of capital investment and a range of performance improvement initiatives including:

- Capital funding to grow diagnostic capacity, via the Constitutional Standards capital allocation process, including through the roll out of 170 CDCs and additional acute trust equipment (as of July 2025).
- Establishment of digitally enabled diagnostic networks to drive diagnostic service productivity growth and speed up test results.
- Clinically led improvement support for systems to adopt a series of best practice approaches on utilisation, demand optimisation and productivity.
- Support to adopt highly productive straight to test pathways which are speeding up diagnosis and enabling patients to receive all their tests in one CDC visit.

Maternity, neonatal and women's health

Progress has been made across the four themes of the three-year delivery plan for maternity and neonatal services.[31] These are: listening to women; workforce; culture and standards; and structures. As we enter the final year of the plan, we continue to work towards the following objectives, with a specific focus on narrowing the inequalities in outcome and experience:

- Continue to make progress towards the national safety ambitions (to reduce stillbirth, neonatal death, brain injury, preterm birth and maternal mortality) and increasing fill rates against funded establishment.
- Establish and develop at least one Women's Health Hub in every ICB by December 2024, working in partnership with local authorities.

With regards to our national safety ambitions, the data shows that stillbirth[32], neonatal death and maternal mortality[33] rates have remained largely stagnant, whilst the rate of brain injury[34] has fallen, and preterm birth[35] rates have increased. Inequalities persist, with women and babies from Black and Asian and the most deprived backgrounds being more likely to experience adverse outcomes.

During 2024/25, maternal mental health services were established in 41 ICBs, with the remaining ICB becoming operational in June 2025 and 63,748 service users were provided support through specialist Perinatal Mental Health Services.

Version three of the Saving Babies' Lives Care Bundle[36] brings together evidence based best practice to reduce perinatal mortality across six elements, including smoking in pregnancy. We have seen a significant and sustained reduction in the smoking-at-delivery rate, with data indicating that, in quarter 4 2024/25, fewer than 6% of women were smoking at delivery. This is the lowest ever recorded rate.[37]

[31] https://www.england.nhs.uk/publication/three-year-delivery-plan-for-maternity-and-neonatal-services/
[32] https://timms.le.ac.uk/mbrrace-uk-perinatal-mortality/surveillance/
[33] https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2024/MBRRACE-UK%20Maternal%20MAIN%20Report%202024%20V2.0%20ONLINE.pdf
[34] https://www.imperial.ac.uk/neonatal-data-analysis-unit/neonatal-data-analysis-unit/reports-brain-injury-surveillance/
[35] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/birthsinenglandandwaleslinkedbirths
[36] https://www.england.nhs.uk/publication/saving-babies-lives-version-three/
[37] https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-women-s-smoking-status-at-time-of-delivery-england/statistics-on-womens-smoking-status-at-time-of-delivery-england-q3-2024-25

There are now more midwives than ever before, with 26,835 WTE employed as of March 2025, marking an increase of 1,700 (6.7%) over the past 12 months. We have seen a sustained decline in leaver and turnover rates. Leaver rates remain at below 5% levels compared to a peak of over 7% following the COVID-19 pandemic. Based on the March 2025 leaver rate of 4.3%, we are retaining approximately 750 WTE more midwives (over 12 months), compared to when leaver rates were at their peak of 7.3% in 2022.

The obstetric workforce is also growing, and we have established a sustainable training route for obstetric physicians to develop specialist skills to work with women with pre-existing medical conditions, during and after pregnancy.

All 150 maternity and neonatal leadership teams have now taken part in the national culture and leadership programme. Each team is implementing culture improvement plans based on feedback from their staff and we are developing the next phase of this programme, which will specifically address racism and discrimination.

Women's Health Hub provision was established or expanded in 42 ICBs during 2024/25. We are planning the publication of a good practice guide to support neighbourhood-level delivery of women's health services to improve access, experience and outcomes for women and girls, for publication in 2025/26.

Mental health

There were seven national NHS objectives for mental health in 2024/25. These objectives primarily focussed on: access to mental health services for adults; children and young people; access to perinatal services; reducing health inequalities; and reducing the number of people inappropriately placed in mental health hospital out of area placements (OAPs).

Improve access to transformed models of mental health care for adults, perinatal, and children and young people

In 2024/25, NHS England began work to develop and provide a nationally led improvement support offer to help local systems improve access to community mental health services for children and young people. This provided clinical and operational leadership support and helped to drive improvements in the quality and effectiveness of services' use of data.

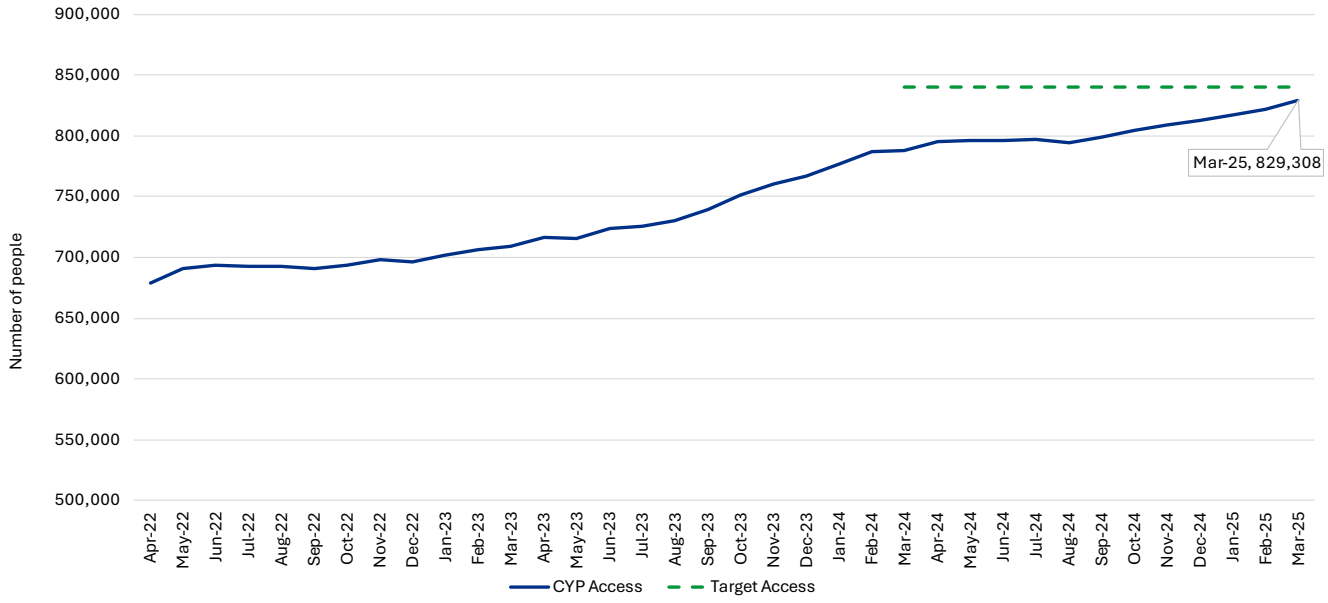
Access to adult community mental health services for transformed models of care increased in quarter 4 2024/25 to 597,374 (target: 400,000).

63,784 women accessed specialist community perinatal mental health services and MMHS in the 12 months to the end of March 2025 (target: 66,000).

Performance against this commitment continues to improve through continued support of regions and clinical networks, and through sharing best practice.

In the 12 months to March 2025 an additional 41,000 children and young people aged between 0-17 accessed mental health services against a target of 840,254 (2024/25: 829,308 compared to 2023/24: 788,108).

The number of children and young people with at least one contact from funded Mental health service

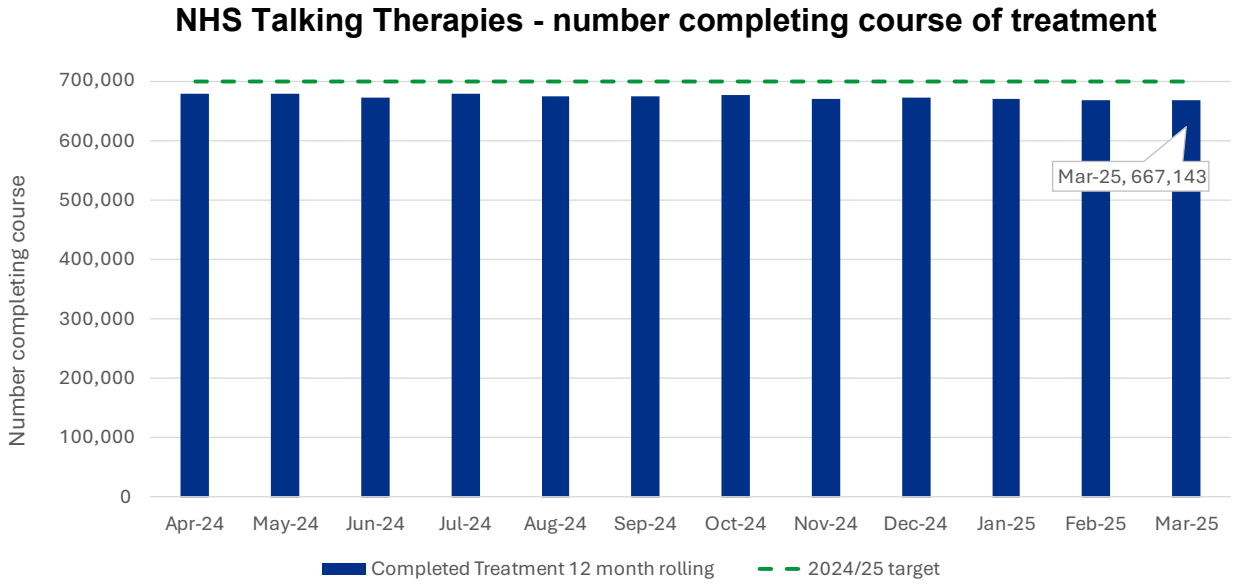


By March 2025, 73.9% of 'routine' children and young people eating disorder referrals were seen within 4 weeks, with 73.1% of urgent referrals seen within one week. Whilst this remains below the standard of 95%, children and young people's community eating disorder services are now treating almost 40% more children and young people compared to pandemic-era levels (2019/20: 8,034, 2023/24: 11,174).

Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies.

NHS England has worked throughout 2024/25 to support the delivery of NHS Talking Therapies, focused on securing workforce training (to enable workforce expansion) and to support providers to increase service capacity. We have supported systems to improve the productivity of Talking Therapies by expanding the use of digital technologies, increasing patient-facing time and freeing up clinical time.

In 2024/25, 667,143 adults completed a course of treatment through NHS Talking Therapies. This is below anticipated trajectories and less than 2023/24 levels due to increased session numbers and workforce growth occurring later in the year than planned, as shown below.



Continue to reduce inequalities by working towards 75% of people with a SMI receiving a full annual physical health check.

People with SMI are at higher risk of poor physical health and at significantly higher risk of obesity, asthma, diabetes, chronic obstructive pulmonary disease and CVD – and are significantly more likely to die prematurely compared to the rest of the population. Physical health checks for people with SMI is a key focus area to help address health inequalities and premature mortality.

Physical health check data for quarter 4 2024/25 March 2025, shows 66.5% of registered patients on a GP register with SMI received a full health check, exceeding the minimum standard of 60%.

Improving quality of life, effectiveness of treatment and care, for people with dementia.

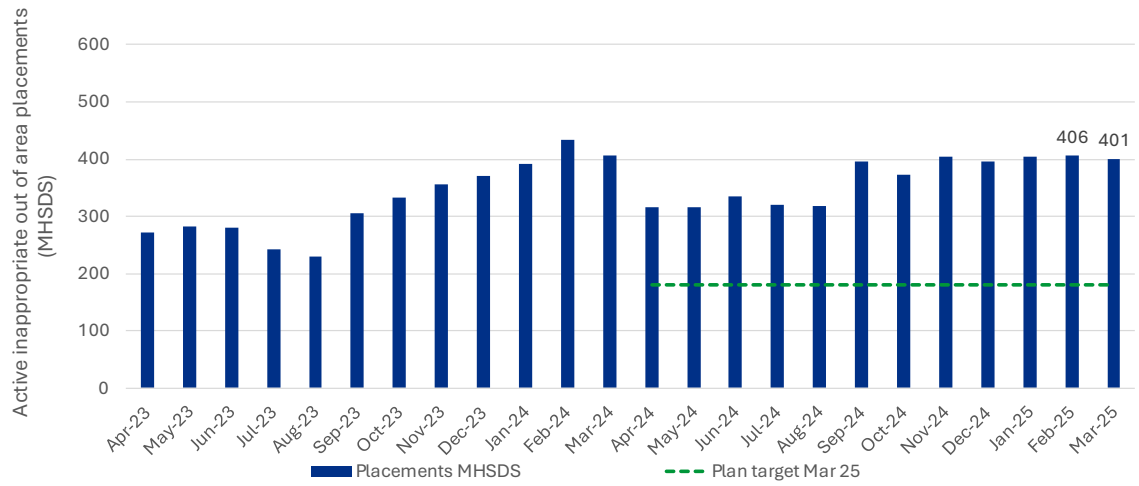
The dementia diagnosis rate for March 2025 is 65.6% (national ambition: 66.7%) and, although marginally short of the 2024/25 target, this is an improvement on previous years (March 2024: 64.8%; March 2023: 63%), demonstrating a consistent year-on-year increase in recovery of the dementia diagnosis rate.

We continued to share best practice across NHS regions and promoted resources aimed at increasing dementia diagnosis, particularly in care home settings. We have encouraged the adoption of the RightCare Dementia Scenario[38] to guide best practice for diagnosing dementia and we have supported ICBs by developing resources, including a self-assessment framework, to help designing integrated dementia pathways.

[38] https://www.england.nhs.uk/long-read/rightcare-dementia-scenario/

Improving patient flow and eliminating inappropriate Out of Area Placements

The number of people in inappropriate OAPs in adult acute beds actively increased from 396 in December 2024 to 401 by the end of the reporting period (March 2025 target: 181 or less), as shown in the following chart.

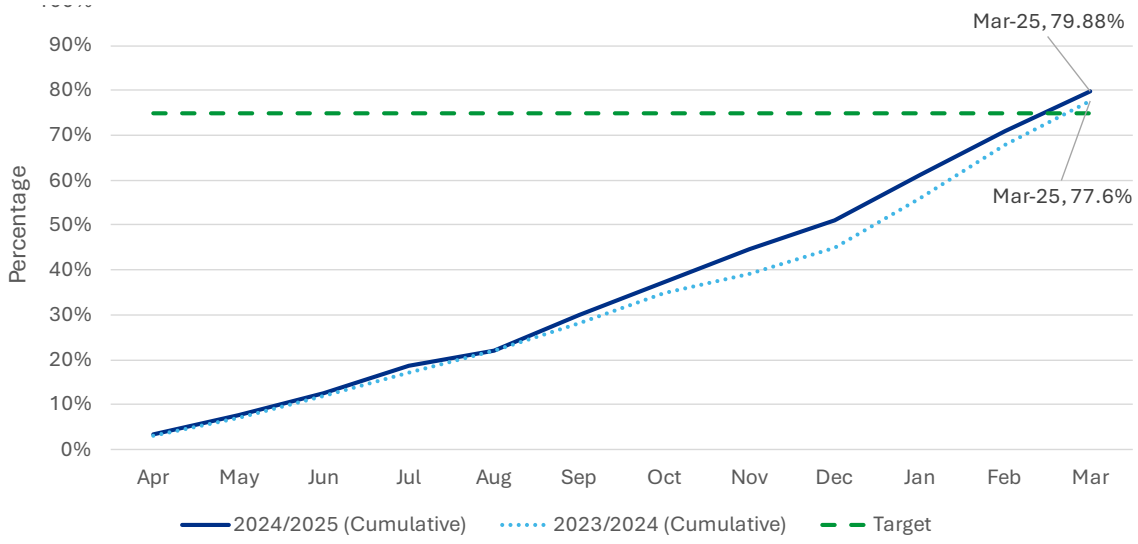


Key challenges driving OAPs include increased demand for mental health services, workforce shortages impacting service capacity, limited local bed availability and quality concerns across mental health services. Additionally, data quality issues persist in both the Mental Health Services Data Set and local data, and further work is underway to investigate and address these data issues.

People with a learning disability and autistic people

The NHS made substantial progress with delivering learning disability annual health checks and accompanying health action plans, both of which are key components for managing health inequalities experienced by people with a learning disability. By March 2025, 79.88% of people aged 14 or over, who were on GP learning disability registers, received an annual health check. This exceeds the national ambition of 75% and previous year's performance (2023/24: 77.55%).

Learning disability annual health checks



Reducing reliance on mental health inpatient care

At the end of March 2025, there were 2,025 people with a learning disability and autistic people in a mental health inpatient setting (baseline at March 2015: 2,910). This represents a decrease of 30% against our NHS Long Term Plan ambition to reduce inpatient numbers by 50% by March 2024. The number of people with a learning disability residing in a mental health inpatient setting decreased by more than 50%, exceeding the national target. However, we have seen the number of autistic people in a mental health inpatient setting increase by more than 130%, including people who were diagnosed as autistic while in hospital.

As of March 2025, there were 223 children and young people (aged under 18) with a learning disability and/or are autistic in a mental health inpatient setting. Keyworker services are in all ICB areas for children and young people with a learning disability and those who are autistic. In 2024, keyworker services reported that they helped avoid a mental health inpatient admission for over 2,000 children and young people.

There were 1,805 adult inpatients as of March 2025, 340 higher than the quarter 4 system planning target of 1,465.

In 2024/25 we made £124 million available in system baselines to enable the development of community intensive support teams, community forensic teams and 24/7 crisis response for people with a learning disability and autistic people. We made £13 million of housing capital available to support people to leave hospital and we have continued to ensure that national guidance and resources for people experiencing mental illness are reflective of the needs of autistic people and those with a learning disability.

Prevention and long-term conditions

By March 2025, 70.3% of hypertension patients (aged 18 and over) were treated in line with NICE guidance. While no systems met the 2024/25 target of 80%[39], between March 2024 and March 2025 922,436 people were diagnosed with hypertension, and 598,403 people had their hypertension managed to target. As of March 2025 CVD Prevent data shows 494 practices have achieved the target of 80% or more.

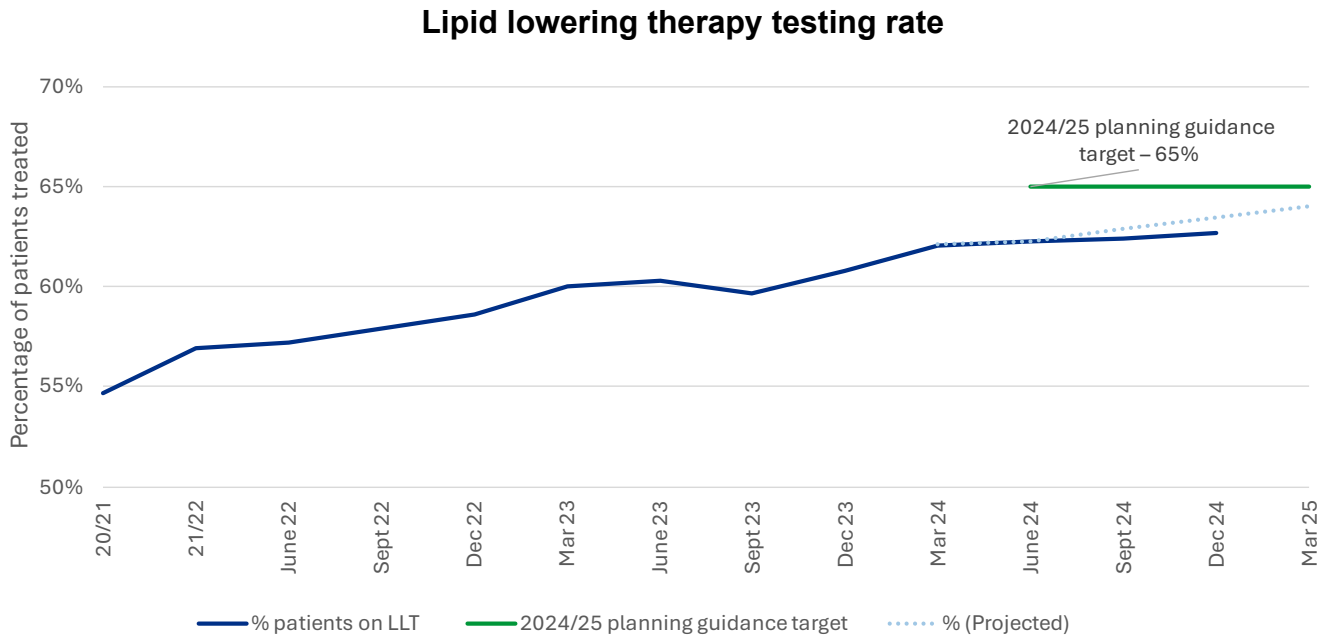
Hypertension performance has been adjusted to incorporate home and ambulatory Blood Pressure readings from the June 2024 data period and all future reporting periods. A GP system fix also led to a drop in performance as, prior to this fix, any patients whose diagnosis was recorded at a previous practice were not included in the data. This increase in surfaced diagnoses led to a reduction in achievement against the 80% treatment target, from June 2024 onwards.

[39] Increase percentage of patients with hypertension treated to NICE guidance to 80% by March 2025

The following initiatives have been the driving force behind improving detection and management of hypertension:

- The CVDPREVENT[40] audit, is an extract of routinely held GP data. CVDPREVENT benchmarks performance at general practice, PCN, system and regional level, whilst also highlighting unwarranted variation and health inequalities. These data sets are used both locally and nationally to inform decision making.
- The NHS Quality Outcomes Framework provides the only financial incentive for primary care to drive up performance.
- NHS England provides funding for CVD leadership in every ICB and provides systems with the freedom they need to identify and address local barriers to improvement.
- Dental and optometry sites have been selected to take part in pilots to test the effectiveness of blood pressure checks in wider primary care settings, and funding has been transferred to systems to enable. All sites are now live. A community of practice group has been set up to support sites to share good practice. The pilots will run until summer 2025 and the evaluation partner (South West Health Innovation Network) will report on their findings by Autumn 2025.

In 2024/25, nationally, 63.6% of patients (aged 18 and over and with a CVD risk score of over 20%), were treated with lipid lowering therapies, with seven of 42 ICBs having achieved the 2024/25 target of 65%. By the end of the reporting period, 265,000 (total circa 3,081,000) additional people were identified as being at high risk of CVD and 183,000 (total circa 1,933,000) more people at high risk of CVD were treated with lipid lowering therapy. Between March 2024 and March 2025 289,383 additional people were identified as being at high risk of CVD and 242,000 more people at high risk of CVD were treated with lipid lowering therapy.



[40] https://www.cvdprevent.nhs.uk/

Transform the way we deliver care and create stronger foundations for the future

Embedding measures to improve health and reduce inequalities

Vaccination and immunisation

Preventing between 3.5 million and 5 million deaths worldwide every year, vaccinations help people stay well and avoid hospital stays. Since introducing many of our vaccination programmes, we have seen reduced annual deaths through the targeting of diseases such as polio, where deaths have been virtually eradicated.

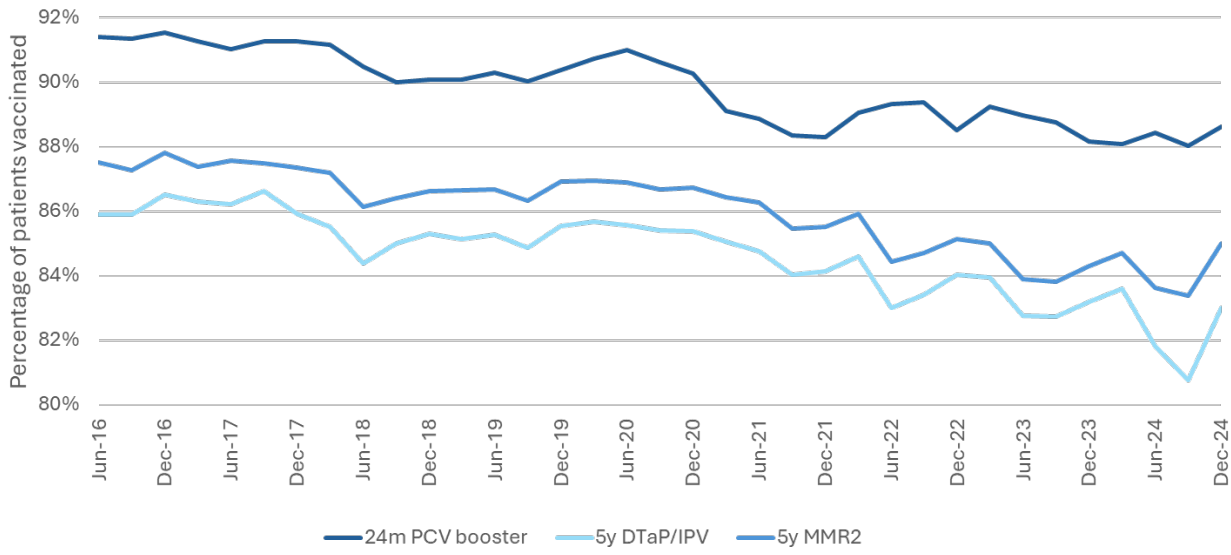
In line with worldwide trends the uptake of vaccines in England has declined over recent years, including for the three key children and young people vaccines (MMR, DTAPIPV and PCV). The need to reverse these downward trends, and to address vaccine confidence and accessibility, remains the focus. All three vaccine types have minimum 90% and optimal 95% immunisation targets in place.

As of December 2024/25, uptake levels fall short of the minimum target and are down against March 2023/24 levels.

- 5-year MMR2 Booster - 85% December 2024 (March 2024: 84.7%)
- 5-year DTaPIPV Booster - 83% December 2024 (March 2024: 83.6%)
- 24-month PCV Booster - 88.6% December 2024 (March 2024: 88.1%)

Nationally, the largest increase for MMR1 was observed in children aged 15 months to 5 years of age (1.8 percentage point increase) and for MMR2, the largest increase was observed in children aged 3 years and 7 months to 5 years of age (3.6 percentage point increase). Over 13% of previously unvaccinated children under the age of 5 years were vaccinated with MMR1 during the NHS Catch Up Campaign for missed MMR Vaccines compared to baseline and, for all cohorts, the greatest improvement in uptake was in the most deprived deciles.

The chart below shows the trends of uptake from quarter June 2016 to December 2024.



The RSV vaccination programme was launched in September 2024 with more than 1.8 million eligible people, including older adults and women of child-bearing age (to protect their newborn babies) receiving the vaccination by the end of the reporting period. Early analysis showed a 30% reduction in hospital admission for people aged 75-79 after just three months.

Screening

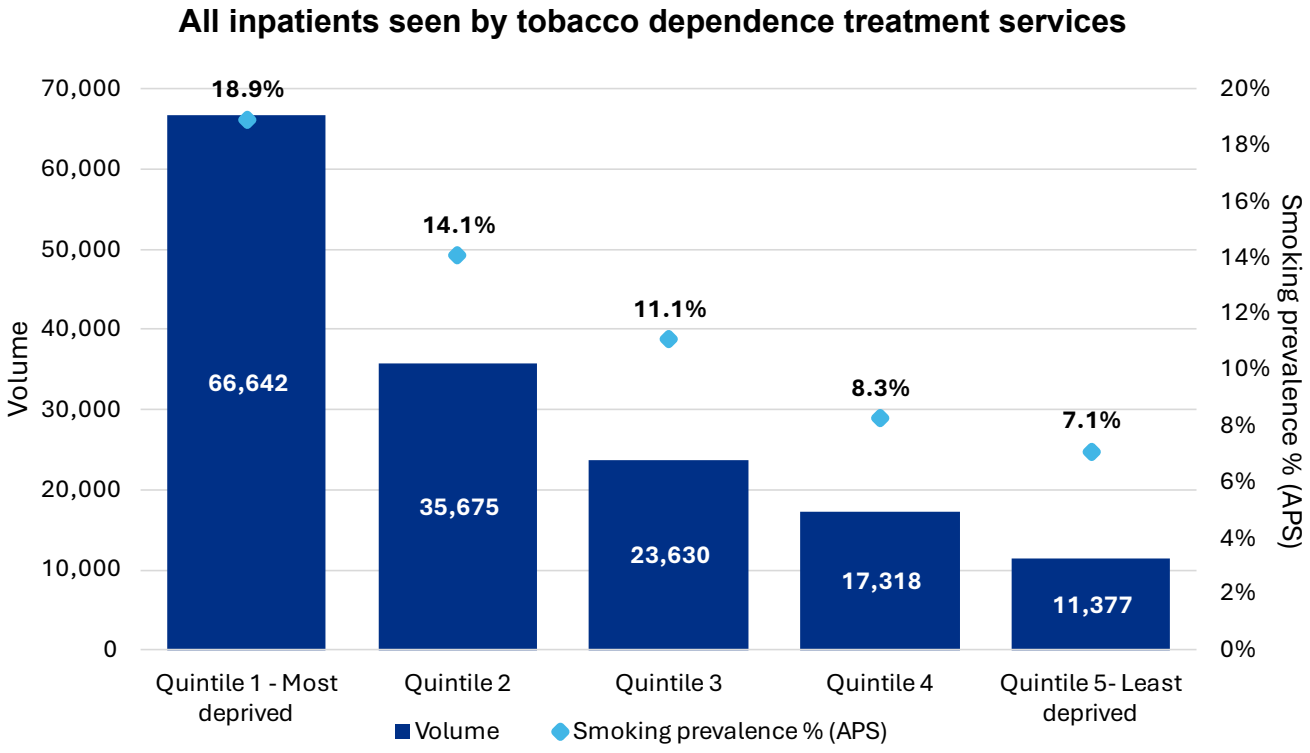
Screening services seek to detect potential health risks early, enabling timely intervention and improved wellbeing. NHS England commissions 12 screening programmes, from newborn screening to abdominal aortic aneurysm screening for older people. With over 19 million screening tests carried out each year, screening saves thousands of lives and identifies problems early, covering a range of conditions.

Bowel Cancer Screening

The plan to have 64 sites live for bowel screening services for the 50 and 52-year-olds demographic has largely been met. Currently, 47 sites (73%) are live for the 52-year-old cohort, and 38 sites (59%) are live for the 50-year-old cohort. Only two sites remain to go live, and they are scheduled to do so later in the financial year.

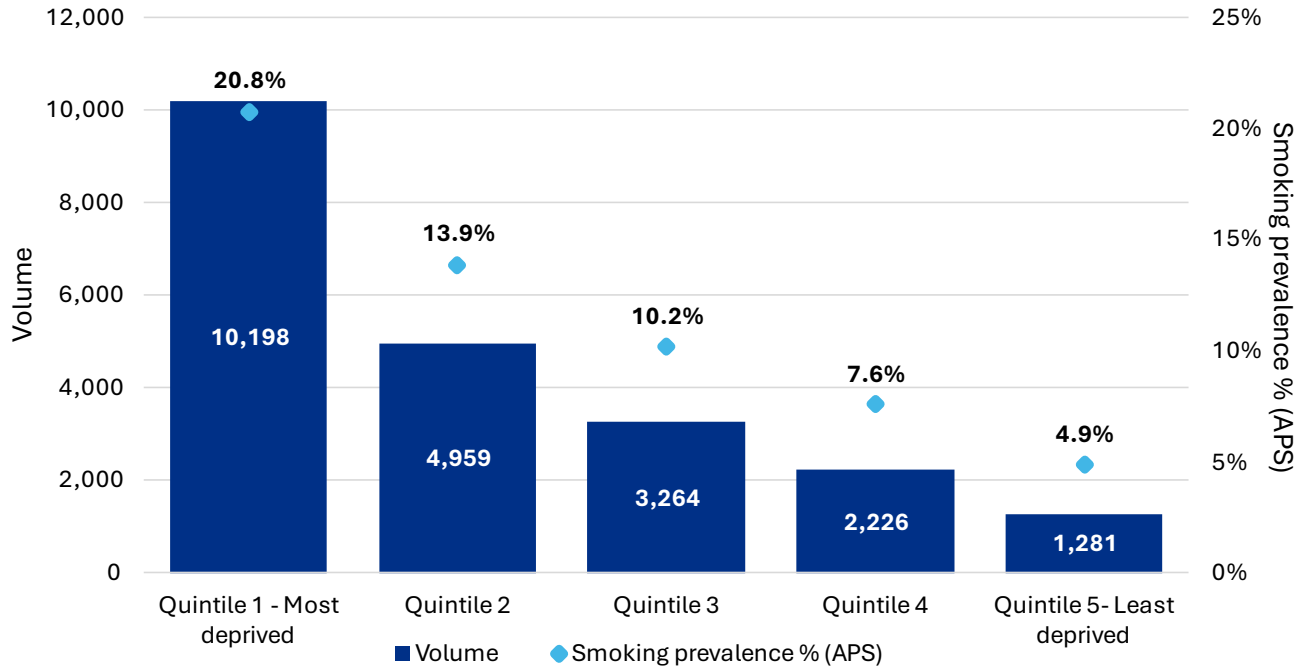
Tobacco dependance

NHS-funded tobacco dependence treatment service have progressed towards universal rollout with 93% of inpatient and 97% of maternity services delivering care to patients at the end of 2024/25. This means that the NHS has supported 121,000 people admitted overnight to hospital and 21,000 pregnant women to make an informed choice about quitting smoking over the 12-month period. This care has focused on those with greatest need with more people identified, seen and engaged in quit attempts from the CORE20 population.



Figures displayed for activity between February 2024 and January 2025

Pregnant women seen by tobacco dependence treatment services



Figures displayed for activity between August 2023 and July 2024

Targeted lung health checks

Lung Cancer Screening services expanded in 2024/25, with almost a million people invited to be assessed. 2.6 million people have been invited since 2019, or 37% of the total eligible population. There have been over 7,000 lung cancers diagnosed through the life of the programme, 3,000 in 2024/25 alone. Of this, over 75% were diagnosed at an early stage, increasing the lung cancer early diagnosis rate by 10.2% compared to 2019, and an improvement of 4.4% just in the last year. The lung cancer screening programme has also greatly benefitted those with the greatest need, with the most deprived quintile, who, because of the programme, are now amongst the most likely to receive an early diagnosis

Overall early diagnosis has improved across all deprivation quintiles, a narrowing in the difference between the most and least deprived from 8.5ppt pre pandemic to 6.5ppt (for the 12 months to March 2025).

Digital Transformation Screening - Cervical, Breast and Diabetic Eye

The implementation of the new NHS Cervical Screening Management System, implemented in June 2024, supports automation of breast screening for the National Disease Registration Service.

Work continues to ensure sufficient MRI capacity is in place to enable timely management of very high-risk screening in accordance with national standards, supported by continuous review and strategic planning around MRI diagnostic capacity and demand, including the introduction of new genetic tests for defined populations.

NHS England is introducing state-of-the-art technology to support NHS screening services, with the launch of digital communications utilising NHS Notify services expected in the first quarter of 2025/26. The private beta of personalised HPV home testing is scheduled for completion by the end of the second quarter, followed by a broader national rollout by the fourth quarter.

Supporting our workforce

The NHS Long Term Workforce Plan (LTWP), published in June 2023 set out ambitions for the workforce across three themes: Train; Retain; and Reform.

In January 2025, the overall NHS workforce increased by 2.6% compared to January 2024.

Train

In 2024/25, NHS England advanced its LTWP commitment to expand the clinical workforce through a coordinated student attraction campaign, an educator workforce strategy and other targeted initiatives. The national clearing campaign, delivered in partnership with UCAS, generated a 25% uplift in traffic to NHS Health Careers. These efforts are part of a broader drive to address falling applications to clinical programmes.

Despite some regional progress, overall student recruitment numbers have declined since the peak seen in 2021/22, and applications for clinical programmes continue to fall. Despite the number of new nursing and midwifery student recruits (new starters) in the first half of 2024/25 being 4% lower than 2023/24, they remain more than 10% higher than pre-pandemic levels, and new Allied Health Professional recruits were at their highest recorded level.

We have supported the allocation of an additional 350 medical school places in the 2025/26 academic year. This builds on an earlier expansion of 205 places in 2024/25 targeting new places in under-doctored areas to help ensure medical school places are available where they are most needed.

Retain

Over 774,800 people from 210 provider trusts participated in the 2024 Staff Survey, which is the highest response level to date. Results were similar to the previous year for all elements of the People Promise, with improved employee engagement scores noted following two years of decline.

The Sexual Misconduct Charter launched in October 2024, encouraging NHS providers to adopt a zero-tolerance approach to sexual misconduct in the workplace and to create a culture at work where everyone feels safe. The proportion of staff reporting unwanted sexual behaviour at work remains similar to 2023 – 8.8% from patients/service users and 3.7% from colleagues.

Staff retention continued to improve during 2024/25, with the overall NHS staff leaver rate standing at 10% as of December 2024 one of the lowest levels in over a decade and below the pre-pandemic rate of 10.7% recorded in December 2019. Organisations participating in the People Promise Exemplar Programme reduced leaver rates more significantly than non-exemplar trusts, collectively achieving an 11.8% greater reduction. At a national level, all rates (excluding sickness rates), are consistently reducing or stabilising at all-time lows.

Recommendations from the Kark and Messenger reviews to improve management and leadership in the NHS continued to be implemented in the year. A new programme was launched in September 2024 to transform NHS Management and Leadership over the next 2 years, to develop our leaders, set the right standards and to support talent and career development.

Reform

As part of our commitment to expand the NHS 'Enhance' programme to improve generalist skills across the first five years of postgraduate medical education for doctors in training, all Foundation doctors now have access to this programme.

Significant progress has been made in achieving our objective to improve the working lives of doctors in training by reducing duplicative payroll errors. In December 2024 payroll errors had been reduced by over 48% across 27 trusts, with targeted interventions achieving up to a 72% reduction in some cases.

We have worked with the General Medical Council to deliver our commitment to build on the Out of Programme Pause pilot to establish this programme as an accepted part of the training pathway. The pilot allows medical trainees to step out of formal training for up to a year to undertake a patient-facing UK based non-training post. We have invested in more pharmacy technicians, through a two-year apprenticeship, with the first cohort of over 500 set to join the community pharmacy workforce in 2026.

Spend on temporary staffing in the NHS has reduced, with 2.3% (£2.1 billion) of the total pay bill being spent on agency staffing in 2024/25, lower than the target of 3.2% (£2.6 billion), representing a significant cost saving and building on the £451 million reduction in the previous year. We have published several toolkits and have worked with providers and commissioners to support with maintaining strong establishment controls and ensure any significant workforce changes will improve workforce productivity.

Digital and data

We have improved patient care and productivity through digital technology and data, ensuring better outcomes for patients and better staff experience. We operate one of the public sector's biggest live service technology estates, the "wiring" which connects the NHS and handles billions of transactions on which patients and staff depend every day. We have advanced major initiatives including the NHS App, the Federated Data Platform (FDP), Electronic Patient Records (EPR) and the NHS Research Secure Data Environments Network. Through our NHS IMPACT and Get It Right First Time programmes, we support the front line to standardise care and continuously improve services using improvement science and data driven clinical peer review.

Live services

We operate over 200 live services including everything from systems which protect children, to those which monitor over 1.9 million computers to detect and prevent cyber threats. Spine, the national health information system on which patients and staff rely on every day, securely processed over two billion transactions this year. Our new Digital GP Registration enables online patient registration with local GPs, with over 60% of registrations completed online as of March 2025. The new Record a Vaccination Service simplifies vaccine data recording, with over 600,000 vaccinations logged since its introduction.

NHS App

The NHS App is the digital gateway to the NHS, providing secure and convenient access to health information and appointment bookings. This year, 94% of the population can manage secondary care referrals directly through the NHS App, reducing Did Not Attend (DNA) rates by over 500,000. It also supports prescription management with over 7.2 million patients managing their prescriptions digitally and 4.8 million repeat prescriptions ordered.

NHS Notify, a new service integrated with the NHS App, enables direct communication with patients, driving substantial savings and further reducing DNA rates. We estimate that around £450 million is spent on patient communications by the NHS annually. The NHS App sends unlimited messages for free. The NHS App has saved over 2 million hours of admin time and 890,000 hours of GP time, alleviating pressure on urgent care services.

Improving the digital maturity of frontline services

We improved the digital maturity of trusts nationwide, by aligning providers with the standards set in our What Good Looks Like framework.[41]

By March 2025, 92% of trusts in England have implemented EPR systems, with 40% reaching the highest capability standards. We are working with the remaining trusts to deploy these systems safely. EPR systems improve patient safety and productivity, resulting in a 13% reduction in the cost per episode of care, a 4% reduction in length of stay, and a 17.5% reduction in sepsis mortality.

Recognising pressures in social care, by the end of March 2025 we had supported 77% (April 2024: 66%) of CQC-registered care providers to implement Digital Social Care Records. This shift is enhancing coordination and continuity of care across the social care system with evidence suggesting at least 20 minutes have been saved per care worker, per shift, as well as time savings across other roles in providers.

Federated Data Platform

The NHS FDP, which was launched in November 2023, integrates operational data to support healthcare professionals with secure information access, enhancing coordinated care and data-driven decisions. As of March 2025, 72 provider trusts use FDP products and 39 of 42 ICBs have benefitted from the platform.

[41] https://transform.england.nhs.uk/digitise-connect-transform/what-good-looks-like/what-good-looks-like-publication/

The FDP has improved elective surgeries, reduced backlogs and ensured timely patient care. By the end of March 2025, the FDP had supported 2.1 million patient pathway (referral to treatment) actions and checks to be completed, helping to ensure patients are treated within NHS recommended target times. Through supporting improved theatre utilisation, on average by more than 8%, an additional 74,996 patients had undergone their procedures in theatres. The FDP has further enabled around 286,000 patients to be safely removed from inpatient and outpatient waiting lists.

The FDP OPTICA product is supporting discharge management in acute settings so that patients are experiencing shorter waits when ready for discharge. An average reduction of 18% in discharge delay days has been observed among patients with the longest stays in hospital, within trusts utilising the FDP OPTICA product.

Cyber

Over the past year, the NHS has bolstered its cyber resilience to counter advanced cyber-attacks and the rapid evolution of artificial intelligence. Our Cyber Security Operations Centre monitors over 1.9 million devices around the clock, preventing numerous disruptive attacks.

We have conducted over 800,000 phishing simulations, launched educational cyber podcasts, and introduced ransomware detection and prevention capabilities. We also issued 160 Cyber Alerts on critical IT vulnerabilities. The Cyber Associates Network, with over 2,800 security professionals, plays a crucial role in sharing information and building cyber capabilities. Their efforts were vital in responding to the Synnovis pathology attack in June 2024, demonstrating the importance of Cyber Operations in maintaining a secure NHS environment.

Innovation, Research and Life Sciences

NHS England has a legal duty to facilitate and promote research and to promote innovation. We have continued to support innovation, research, and the life sciences to improve patient outcomes and staff experience, whilst reducing health inequalities.

Research and innovation are more important than ever, playing a crucial role as the NHS seeks to address operational pressures and increase productivity. These factors also mean that frontline staff, researchers, and the life sciences industry report a challenging picture broadly in the health innovation ecosystem. Work has therefore continued to ensure that the NHS remains a partner for research and innovation.

During the reporting period, key activities included:

- Support for over 590,000 people to sign up as research volunteers through the National Institute for Health Research (NIHR) Be Part of Research portal.
- The implementation of the National Contract Value Review process across all phases of clinical trials contributing to a 36% reduction in commercial clinical trial set up times.
- In April 2024, NHS England published guidance to help providers understand research finance, which differs from NHS finance more generally.[42]

[42] https://www.england.nhs.uk/publication/managing-research-finance-in-the-nhs/

- Through the Research Engagement Network Development programme, allocated £4.5 million to ICB-NIHR-VCSE partnerships in all 42 ICBs. This resulted in more than 28,000 people from underserved communities attending Research Engagement Network public-facing events. More than 10,000 people, including 280 community champions, were invited to join research studies.
- Accelerated access to data for research through the NHS Research Secure Data Environment (SDE) Network. SDEs supported over 240 research studies, surpassing the target of 192.
- Supported nine national priority trials through NHS DigiTrials, recruiting 8,000 participants for heartburn research and 400 for melanoma studies.
- Identified 20 Alzheimer's Disease digital technologies to enter the National Institute for Health and Care Excellence Early Value Assessment process using our Horizon Scanning capabilities.
- Welcomed the latest cohort onto the NHS Clinical Entrepreneur Programme, taking the total number of entrepreneurs supported on the programme to over 1,100. We also launched the first Patient Entrepreneur Programme.
- Appointed 27 fellows to the NHS Innovation Accelerator programme, the largest cohort yet, who will receive mentoring and tailored support to scale their innovations.
- Supported 18 NHS Innovation Sites through the InSites programme, to build capacity and capability for adoption and scale of innovations which map to their local population health needs.
- Undertaken significant system modelling and forward planning activity to support system readiness and pathway transformation needed to adopt innovative new medicines that could impact over 650,000 patients.
- The Digital Trailblazer programme supported 3 NHS Talking Therapies sites through a 100-day challenge to optimise patient-facing digital tools, leading to measurable improvements in access to Digitally Enabled Therapy.
- The SBRI Healthcare competition awarded £1.7 million to nine innovative projects focused on enhancing workplace mental health through digital solutions. Supported over 1,000 innovations and innovators through the NHS Innovation Service an online platform that helps innovators introduce new solutions to the NHS. 172 were also given a route to market.

System Working

In 2024/25, NHS England has supported ICBs and their partners to develop their systems to meet their population's health needs, by providing further clarity on roles and responsibilities of individual organisations, and how systems can organise their decision making to hold each other to account for delivery of shared system plans and system statutory duties.
The publication of The Insightful Board guidance[43] provides advice on what information NHS boards should pay attention to in discharging their duties.

To support systems to meet local population health goals through the development of their place architecture, NHS England has developed a working toolkit to help local areas consider different approaches to accountability, delegation, contracting and commissioning. In January 2025, NHS England also published Neighbourhood Health Guidelines[44] which set out the core components of a neighbourhood health model that every ICB should be delivering.

[43] https://www.england.nhs.uk/leaders/insightful-board-guidance/
[44] https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/

NHS England has continued to provide support to ICBs to implement population health management (PHM) capabilities this year. There are now over 12,500 members of the nationally hosted PHM Academy which provides a range of e-learning for neighbourhood teams, good practice case studies and guidance on more technical aspects of joining up data and analysing risk factors. Additionally, there have been 11 peer learning events this year for ICB teams to understand how to implement PHM and learn from international best practice.

NHS England has also supported provider collaboratives during the year, to fully realise the benefits of working at scale and encourage best practice in meeting system priorities. This has included delivery of a programme of webinars, case studies and peer learning sessions.

Independent patient choice and procurement panel

Since 1 January 2024 NHS England has hosted the independent panel for patient choice and procurement.[45] The panel has responsibility for:

- reviewing representations from providers about qualification of providers by ICBs for services where the legal rights to choice apply.
- providing advice to relevant authorities about decisions under the Provider Selection Regime.

Cases can be referred to the independent panel where other processes have not resolved the issues. During 2024/25 the panel published advice on six provider selection cases.

Sustainability

The NHS has committed to reducing greenhouse gas emissions (GHGs) under our direct control (the NHS Carbon Footprint) to 3,200 $ktCO_2e$ by 2028 to 2032 and to net zero by 2040. Estimated emissions in 2024/25 were 4,350 ktCO2e, down from an updated estimate of 4,450 ktCO2e for 2023/24. Further breakdown is provided on page 194. Progress was supported by targeted action across the NHS during 2024/25, including:

- £900k to support a reduction of nitrous oxide waste, which has been shown to be up to 80% at some sites.
- Increasing electrification across the NHS fleet, with 10% of all vehicles now zero emission.
- Securing over £200 million to decarbonise the estate, through the Public Sector Decarbonisation Scheme, taking the total awarded to the NHS through Public Sector Decarbonisation Scheme to over £1 billion.
- Investing around £90 million in energy efficiency measures, through the National Energy Efficiency Fund.
- The announcement in March 2025 that £100 million would be jointly invested with Great British Energy in solar generation projects across the country.

This estimate, combined with evidence of action across the NHS, suggests that in 2024/25 the NHS was on track to meet our commitments for 2028-32 and demonstrates progress towards our ambitious 2040 net zero target.

[45] https://www.england.nhs.uk/commissioning/how-commissioning-is-changing/nhs-provider-selection-regime/independent-patient-choice-and-procurement-panel/panel-reports/

Chief Financial Officer's report

The financial statements for the year ending 31 March 2025 are presented later in this document on a going concern basis (as per Note 1.5 of the accounts) and show the performance of both the consolidated group – covering the whole of the commissioning system – and NHS England as the parent of the group. The group comprises NHS England the 42 ICBs and Supply Chain Coordination Ltd (SCCL).

As part of the merger of NHS England, NHS Digital and Health Education England, NHS England successfully delivered a 35% reduction in its organisational size, resulting in £490 million of savings. In addition, through robust financial management and further efficiencies in central NHS England costs, an additional £306 million in savings was achieved. In total, £500 million of these savings were reinvested into frontline services, directly supporting patient care and system delivery. Across systems, the total efficiency in 2024/25 totalled £8.7 billion. This represents a 21% increase compared to the £7.2 billion of efficiencies delivered in 2023/24.

NHS England is required to manage total NHS spending within a fixed revenue limit. The total General RDEL limit for 2024/25 was £190,990 million.

Funding and allocations

In 2024/25, core funding for the NHS on a like-for-like basis increased by 0.2% taking account of the funding announced at the Spring Budget. An additional £2.3 billion was allocated to NHS systems to support them in achieving financial balance and breaking even. During the year, further funding was made available to meet emerging and exceptional pressures. This included £5.7 billion to cover the higher-than-anticipated costs of the 2024/25 pay awards, which affected multiple staff groups across the NHS. A further £184 million was allocated to offset the additional costs arising from industrial action, ensuring continued service delivery and mitigating financial risk to providers.

Additional funding was also agreed for technology investment and the ongoing delivery of the COVID-19 vaccination and testing programmes.

ICB allocations continued to include the Elective Recovery Fund, made available by the Government to support the recovery of elective waiting lists. The allocations issued through ERF totalled £6.2 billion.

From 1 April 2024, 20 ICBs in East of England, Midlands and Northwest regions took on delegated responsibility for the commissioning of specialised services, and received an additional allocation related to those services. From 1 April 2025, all 42 ICBs have now taken delegated responsibility for the commissioning of specialised services.

Operational pressures

Over the year, ICBs and trusts worked with local authorities to improve discharge processes and increase capacity to support timely discharge from hospital. There was a small reduction in levels of delayed discharges compared to 2023/24 however challenges remain. On average there were around 12,633 patients per day with delayed discharges, highlighting the continued pressure on flow across health and social care services.

Recurrent capacity funding to support systems to deliver improved urgent and emergency care performance was added to core programme allocations in 2024/25. A&E performance improved from 74% in March 2024 to 75% in March 2025. Latest published figures show that the number of patients in a Virtual Ward (also known as hospital at home) decreased by 1% in the past year, (July 2024: 9,132, July 2025: 9,002).

The NHS has delivered around £8.7 billion of savings and continues to deliver improvements in productivity of around 2%, allowing us to improve operational performance in key areas including reducing elective waiting lists. The waiting list decreased by 120k in 2024/25 and Referral to Treatment Time performance improved by 2.6 ppt.

Timeliness of local accounts

In preparing the NHS England group accounts based on consolidation schedules from ICBs, we are reliant on each ICB submitting their audited annual report and accounts to us. We and the DHSC issue directions to NHS bodies on the timing by which these should be submitted.

There are many reasons why a set of audited accounts for a local NHS body may go beyond the deadline: for example, this may reflect illness in the preparer finance team or audit team, or a significant issue may be encountered that takes time to resolve, which may reflect weaknesses in an entity's preparation of its accounts. Auditors need to be able to complete their work independently of outside influence and take the necessary time to ensure their audit opinion is the right one and supported by appropriate audit evidence. It is also important that there is a properly functioning local audit market to allow audited bodies to hold their auditors to account for delivery. We welcome the Financial Reporting Council's publication of its NHS Audit Market Study.[46]

The timeline on which these national accounts are finalised depends on both when the deadline for local audited accounts is set, and compliance with that deadline. For many years prior to 2019/20 the local audit deadline in the NHS was around the end of May. The deadline is set in consultation with the audit firms on what they are willing to sign up to. In recent years the local audit deadline has been around the end of June.

In recent years in the NHS England annual report, we have described NHS England's limited direct role in NHS audits but detailed the steps we have been taking to improve compliance with the local deadline for audited accounts in the NHS.

[46] https://media.frc.org.uk/documents/NHS_Audit_Market_Study_Final_Report.pdf

More NHS bodies achieved the deadline for submission of audited accounts in 2024/25 than in recent years. 92% of local NHS bodies (being NHS providers and ICBs) met the deadline in 2024/25, the highest proportion since 2019/20. All ICBs submitted audited accounts on time this year, (2023/24: 90%, 2022/23: 74%).

NHS England and the DHSC have worked closely with the Ministry of Housing, Communities and Local Government on the relevant elements of its work to reform 'local' audit. In July 2025 MHCLG laid the English Devolution and Community Empowerment Bill[47] before Parliament, part four of which makes changes to the local audit system in England and Wales. The reforms include establishing the Local Audit Office, a body to coordinate local audit with responsibilities including determining the framework for auditors to follow, rules for eligibility to be a local auditor, and inspection and enforcement. Bringing these functions together will help set the foundation to strengthen the audit market. These changes directly apply to audits of NHS trusts and ICBs; the DHSC and NHS England are exploring ways to replicate them for NHS foundation trusts.

As well as reforms to the local audit system, we have continued our broader work to improve timeliness in NHS financial reporting including:

- encouraging auditors to give clear reporting to audit committees where the preparer's quality of draft accounts or working papers needs to improve
- working closely with NHS bodies to ensure they appoint external auditors in good time, which helps increase the likelihood of deadlines being achieved
- working with NHS bodies where financial reporting issues arise to ensure they are able to address findings effectively
- regular engagement with the audit firms and responding to their feedback to continue to strengthen the NHS financial reporting landscape, and working with partners to make sure training and guidance is available for preparers and
- liaising with broader stakeholders on wider matters that can cause delays in NHS accounts.

NHS England and the DHSC have an ambition to return to laying the main national consolidated accounts (being the DHSC group, NHS England group and consolidated provider accounts) before Parliament in advance of the summer Parliamentary recess in July. Achieving this in the years ahead would require the audit community to accept a significantly earlier deadline for audited accounts than is currently the case. At the present time it is not clear that this is achievable in the short term. We will continue to focus on streamlining processes for preparation and audit of local and national accounts to the extent this falls within our role to seek to facilitate the earlier finalisation of accounts wherever possible.

[47] https://bills.parliament.uk/bills/4002/publications

Financial performance

Revenue Department Expenditure Limit (RDEL) general (non-ringfenced)

The DHSC sets several technical financial targets for the NHS England Group, including the core operational limit (general RDEL) described in the table below. These limits are ringfenced, which means that underspends on the other revenue limits cannot be used to support core patient services covered by the general RDEL limit.

	2024/25				2023/24		2022/23		2021/22		2020/21		2019/20	
Financial performance	Expenditure plan	Expenditure actual	Under/(over) spend against plan		Under/(over) spend against plan		Under/(over) spend against plan		Under/(over) spend against plan		Under/(over) spend against plan		Under/(over) spend against plan	
	£m	£m	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%
ICBs[48]	151,017	150,872	145	0.1%	(122)	(0.1%)	64	0.1%	195	0.2%	154	0.2%	(507)	(0.6%)
Direct commissioning	24,219	24,147	72	0.3%	297	1.1%	552	1.8%	310	1.1%	1,087	3.9%	390	1.5%
NHS England admin / central programmes / other[49]	15,754	15,174	580	3.7%	1,080	7.9%	537	5.7%	192	2.9%	4,132	21.3%	1,113	14.2%
Total	**190,990**	**190,193**	**797**	**0.4%**	**1,255**	**0.7%**	**1,153**	**0.7%**	**697**	**0.5%**	**5,373**	**3.6%**	**996**	**0.8%**

2024/25 performance against key financial performance duties

a) Revenue limits

	2024/25					2023/24
	Limit £m	Actual £m	Underspend £m	Target met	Underspend as % of limit	Underspend £m
RDEL – general	190,990	190,193	797	✓	0.4%	1,255
RDEL – ring-fenced for depreciation and operational impairment	393	329	64	✓	16.3%	44
Annually Managed Expenditure limit for provision movements and other impairments	250	(28)	278	✓	111.2%	230
Technical accounting limit (e.g., for capital grants)	250	214	36	✓	14.4%	10
Total revenue expenditure	**191,883**	**190,708**	**1,175**		**0.6%**	**1,539**

b) Administration costs (within overall revenue limits above)

Total administration costs	2,161	1,769	392	✓	18.1%	235

c) Capital limit

Capital expenditure contained within our capital departmental expenditure limit	626	611	15	✓	2.4%	53

[48] ICBs were formed on 1 July 2023. All figures on this row prior to 1 July 2023 relate to CCGs.
[49] Supply Chain Coordination Ltd included in 'other'

Financial priorities for 2025/26

Our priorities[50] continue to centre on the recovery of core services and productivity across the NHS. Key to delivery is making sure that the frontline of the NHS has the resources and support it needs to deliver on our priorities for patients, with a focus on reducing the time people wait for elective care, improving A&E waiting times and ambulance response times, improving patients' access to general practice and urgent dental care, and improving patient flow through mental health crisis and acute pathways, including improving access to children and young people's mental health services.

At the heart of delivery are our staff. We must continue to recognise their ongoing efforts and ensure that all colleagues are well supported, so that they can keep doing their best work for patients.

For 2025/26 we will be working with ICSs to:

- reduce ICB running costs by 50% and reversing corporate cost growth by 50% across NHS providers, as well as in NHS England ahead of the integration with the DHSC.[51]
- support the delivery of system financial plans, with targeted support for the more financially challenged systems to help them recover and maintain financial stability over the medium term.
- reduce agency and bank spend as a proportion of the total pay costs for the year, by 30% for agency and 10% for bank.[52]
- use the specific resources we have been provided with to reduce the number of people waiting for elective procedures, with a continued focus on improving access to planned care and addressing long waits.
- maintain robust spending controls and deliver care as efficiently as possible in the context of ongoing operational constraints. We will also intervene proactively where there is a risk of non-delivery to board approved plans ensuring accountability and timely course correction.

Elizabeth O'Mahony, Chief Financial Officer

[50] https://www.england.nhs.uk/long-read/2025-26-priorities-and-operational-planning-guidance/
[51] https://www.england.nhs.uk/long-read/working-together-in-2025-26-to-lay-the-foundations-for-reform/
[52] https://www.england.nhs.uk/long-read/revenue-finance-and-contracting-guidance-for-2025-26/

Accountability report

Sir James Mackey, Accounting Officer

21 October 2025

The accountability report sets out how NHS England meets key accountability requirements to Parliament and is comprised of three key sections:

The corporate governance report sets out how the organisation was governed during 2024/25, including membership and organisation of our governance structures and how they support achievement of our objectives. The report includes:

- Directors' report (from page 52)
- Statement of Accounting Officer's responsibility (page 66)
- Governance statement (from page 67)

The remuneration and staff report sets out our remuneration policies for executive and non-executive directors (NEDs) and how these policies have been implemented for the reporting period, including salary information and pension liabilities. The report provides further detail on remuneration and staff and starts from page 86.

The parliamentary accountability and audit report (from page 113) brings together key information to support accountability to Parliament, including a summary of fees and charges, contingent liabilities and the Certificate and Report of the Comptroller and Auditor General to the Houses of Parliament.

Accountability to Parliament and the public

During 2024/25, NHS England has continued to work closely with the NAO in their work to test whether public bodies are delivering value for money. During this period, the Chief Executive and other senior leaders gave evidence to Public Accounts Committee (PAC) hearings on Addressing the risks of antimicrobial resistance[53], the DHSC Annual Report and Accounts 2023/24[54], Fixing NHS dentistry[55] and NHS financial sustainability.[56]

In 2024/25, the NAO published reports on NHS England's management of elective care transformation programmes[57], Antimicrobial resistance[58], NHS dental recovery plan[59], Progress in preventing CVD[60], and NHS financial management and sustainability 2024.[61]

This resulted in 34 PAC recommendations involving NHS England, of which 29 were accepted, and 19 NAO recommendations of which 17 were accepted.

The 10-Year Health Plan sets out how the government will deliver an NHS fit for the future and addresses many of these recommendations through the three big shifts (hospital-centred to community-based care, from analogue to digital, and from sickness to prevention), a rigorous approach to financial discipline and shift to longer-term planning, and a relentless focus on delivering value-based healthcare.

In response to the PACs recommendations, NHS England has:

- continued to support the NHS to recover lost productivity caused by the COVID-19 pandemic through increasing clinical and operational productivity training and maximising the use of digital innovations to improve the efficiency of services[62]
- continued work to improve access to NHS dental care through working with ICBs to deliver 700,000 extra urgent dental appointments per year from 2025/26 onwards
- continued to implement targeted recruitment and retention initiatives for areas struggling to recruit NHS dentists and developed changes to the current dental contract focussing on supporting access for higher needs patients and encouraging increased use of preventative dentistry.[63]

Bi-annual updates are provided to the Government on all open PAC recommendations via HMT's Treasury Minute progress reports.[64]

[53] https://committees.parliament.uk/work/8826/antimicrobial-resistance-addressing-the-risks
[54] https://committees.parliament.uk/work/8819/dhsc-annual-report-and-accounts-202324/
[55] https://committees.parliament.uk/work/8828/fixing-nhs-dentistry
[56] https://committees.parliament.uk/work/8575/nhs-financial-sustainability
[57] https://www.nao.org.uk/reports/nhs-englands-management-of-elective-care-transformation-programmes/
[58] Investigation into how government is addressing antimicrobial resistance - NAO report
[59] https://www.nao.org.uk/reports/investigation-into-the-nhs-dental-recovery-plan/
[60] https://www.nao.org.uk/reports/progress-in-preventing-cardiovascular-disease/
[61] https://www.nao.org.uk/reports/nhs-financial-management-and-sustainability-2024/
[62] https://assets.publishing.service.gov.uk/media/682474aeb296b83ad5262ec5/Government_Response_to_the_Committee_of_Public_Accounts_on_the_Fifth_and_the_Tenth_to_the_Seventeenth_reports_from_Session_2024-25_-_Treasury_Minutes_WEB.pdf#page=5
[63] https://assets.publishing.service.gov.uk/media/684fecc877c424182b0c4e5d/E03381954_CP_1341_Treasury_Minutes_Accessible.pdf
[64] Treasury minutes progress report - GOV.UK

Corporate governance report

Directors' report

The Board

The key responsibility of the Board is to provide strategic leadership to the organisation, including:

- setting the overall direction of NHS England, within the context of the NHS Mandate from government
- approving the business plan, which is designed to support achievement of our strategic objectives and monitor our performance against it
- holding the NHS Executive to account for this performance and for the proper running of the organisation, including operating in accordance with legal and government requirements
- determining which decisions, it will make and which it will delegate to the executive or committee or sub-committee, via the Scheme of Delegation
- ensuring high standards of corporate governance and personal conduct
- monitoring performance against core financial and operational objectives
- providing effective financial stewardship
- promoting effective dialogue between NHS England, government departments, partners, ICSs, providers of healthcare and the communities served by the NHS.

In accordance with paragraph 2 of Schedule A1 to the 2006 Act (also set out in section 4.1 of the Standing Orders), the Board comprises the chair, ten NEDs and five executive directors including the chief executive.

Appointments

The chair and NEDs are appointed by the Secretary of State for Health and Social Care and executive members of the NHS England Board are appointed by the chair and NEDs.
The appointment of the chief executive is subject to the Secretary of State for Health and Social Care's consent. The Board also approved the appointment of two associate NEDs in April 2024.

Board members

Directors who served on the NHS England Board during the year are listed in the table below, along with their attendance.[65]

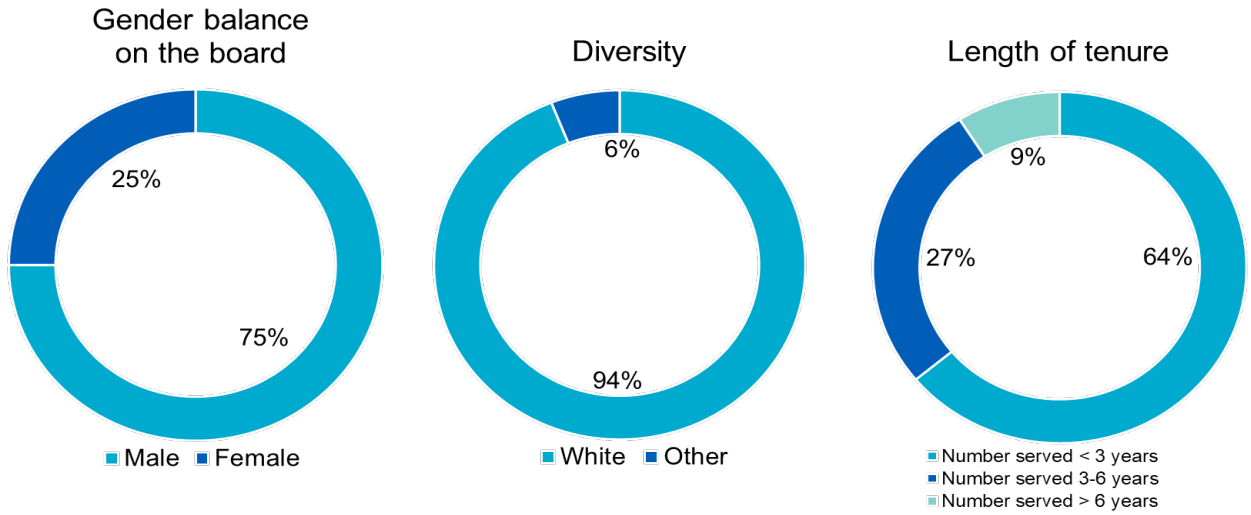
Members	Role	Term ends	Number of eligible Board meetings attended
Richard Meddings[66]	Chair	31 March 2025	6/6
Sir Andrew Morris[67]	Deputy Chair	24 September 2025	6/6
Mike Coupe[68]	Non-Executive Director	31 July 2025	5/6
Jeremy Townsend	Non-Executive Director	30 September 2026	4/6
Professor the Baroness Mary Watkins	Non-Executive Director	31 July 2025	5/6
Professor Sir Mark Walport	Non-Executive Director	24 June 2025	5/6
Professor Sir Simon Wessely	Non-Executive Director	31 July 2025	5/6
Professor Sir Robert Lechler	Non-Executive Director	18 February 2027	6/6
Jane Ellison	Non-Executive Director	31 July 2025	6/6
Mark Bailie	Non-Executive Director	18 February 2027	4/6
Suresh Viswanathan	Associate Non-Executive Director	1 October 2025	5/6
Amanda Pritchard	Chief Executive Officer	31 March 2025	6/6
Julian Kelly	Chief Financial Officer	31 March 2025	6/6
Duncan Burton[69]	Chief Nursing Officer for England		5/5
Professor Sir Stephen Powis	National Medical Director	20 July 2025	5/6
Dame Emily Lawson	Chief Operating Officer	31 March 2025	5/6

Former members	Role	End date
Sir David Behan	Non-Executive Director	31 August 2024
Professor Dame Helen Stokes-Lampard[70]	Non-Executive Director	14 October 2024
Wol Kolade[71]	Deputy Chair	24 March 2025
Tanuj Kapilashrami[72]	Associate Non-Executive Director	23 March 2025
Dame Ruth May	Chief Nursing Officer	24 July 2024

[65] Biographical details may be viewed on our website https://www.england.nhs.uk/about/nhs-england-board/our-leadership-team/
[66] Richard Meddings's term as Chair ended on the 31 March 2025.
[67] Sir Andrew Morris's term as non-executive director was extended for six months, from 25 March to 24 September 2025.
[68] Mike Coupe, Professor the Baroness Watkins, Professor Sir Mark Walport, Professor Sir Simon Wessely and Jane Ellison resigned and their non-executive directorships ended in July 2025.
[69] Duncan Burton was appointed as Chief Nursing Officer for England on the 25 July 2024.
[70] Professor Dame Helen Stokes-Lampard resigned and her non-executive directorship ended on 14 October 2024.
[71] Wol Kolade's term as non-executive director ended on the 24 March 2025.
[72] Tanuj Kapilashrami resigned and her term ended on 23 March 2025.

Board diversity

The charts below show the composition of the Board members by gender, diversity, and tenure as of 31 March 2025.



The governance structure

An overview of the Board governance framework is shown on the next page and individual Board committee reports can be found from page 55 to 64. A report detailing the business considered by the board committees is provided for each Board meeting.

Board activity and administration

There were six NHS England Board meetings during the year, each including a public and private session. The option for members of the public to attend public sessions in person was available throughout the year. Public sessions were live video streamed and published on our website along with the agenda, papers, and minutes.[73]

In addition to the six formal meetings, the Board held two strategy sessions and various subject-specific workshops and deep dives.

Throughout the year, the Board focused on ensuring the integrity and effectiveness of NHS England's strategic, performance, and governance functions. In relation to strategy, it reviewed transformation, innovation and research, strategic priorities for mental health, the future operating model for primary care, transformation of the frailty pathway, the New Hospital Programme, and the NHS productivity programme. It also considered the long-term infrastructure strategy project, the revised NHS Performance and Assessment Framework, and the NHS LTWP.

[73] https://www.england.nhs.uk/about/nhs-england-board/meetings/

In terms of performance, the Board received regular updates on operational and financial performance, winter planning and preparedness, and the delivery plan for recovering access to primary care. It reviewed the annual report on healthcare inequalities and the NHS Race and Health Observatory, the learning disability and autism programme, work on the attention deficit hyperactivity disorder pathway, and progress on the Maternity and Neonatal Three-Year Delivery plan.

In relation to governance and risk, the Board conducted the annual board effectiveness review for 2023/24, assessed risk appetite, reviewed delegation of commissioning functions to ICBs, and ensured robust oversight of NHS England's operations.

Review of Board effectiveness and performance evaluation

In July 2024, the Board received the findings of the 2023/24 NHS England Board governance effectiveness review and endorsed the recommendations and actions. The review identified several areas that had improved, including the operation of the Board committees. Recommendations for improvement were made in relation to duplication of discussions across committees and groups, the role and responsibilities of the Quality Committee including the interaction with other quality fora, and the timely distribution of papers. The review recommendations and actions were implemented during 2024/25.

Events after the reporting period

In addition to the appointment of Dr. Penny Dash as Chair and Sir James Mackey as Chief Executive Officer, several new members joined the executive team on 1 April 2025. Further executive and non-executive director appointments were made after the reporting period, and our website[74] is updated regularly to reflect these appointments.

Further detail on the changes and mergers for ICBs can be found within Note 20 on page 172.

[74] https://www.england.nhs.uk/about/nhs-england-board/our-leadership-team/

Board committees

Audit and Risk Assurance Committee (ARAC)

Role	The committee's primary role is to provide assurance to the Board about the integrity of NHS England's financial statements and the comprehensiveness, reliability and integrity of its internal control, risk management and governance processes.
Frequency	The committee met five times in the financial year.
Membership	The committee is made up of five NEDs and one non-voting member. Additional attendees are invited to meetings to assist with committee business. The committee can meet with the internal and external auditors without management when required, and the auditors have direct access to the Board Chair and committee chair to support independence.
Principal activities during the year	ARAC approved the internal audit plan and reviewed regular progress reports, including the annual Head of Internal Audit Opinion. The committee evaluated risk management governance and reviewed NHS England's principal risks. The Counter Fraud strategy was reviewed. The committee also assessed the integrity of NHS England's financial reporting and approved the 2023/24 Annual Report and Accounts. Additionally, it reviewed details of losses and special payments and considered NAO reports and management letters, including updates on the NAO Value for Money Programme.

Members	Number of eligible meetings attended	Comment
Jeremy Townsend (Chair)	5/5	Non-Executive Director
Wol Kolade	4/5	Non-Executive Director
Mark Bailie	4/5	Non-Executive Director
Mike Coupe	4/5	Non-Executive Director
Jane Ellison	4/5	Non-Executive Director
Gerry Murphy[75]	2/2	Non-executive Chair of DHSC's Audit Committee (non-voting member)
Richard Douglas[76]	3/3	Non-executive Chair of DHSC's Audit Committee (non-voting member)

[75] Gerry Murphy stepped down from the DHSC Board, and as Chair of its Audit and Risk Committee, in July 2024.
[76] Richard Douglas joined the committee membership from 13 September 2024, replacing Gerry Murphy.

Nominations Committee

Role	The committee oversees succession planning for the NHS England Board and senior management, board composition and board evaluation.
Frequency	The committee met three times in the financial year.
Membership	The committee is made up of the Chair of NHS England, three NEDS and the CEO. The Director of Human Resources and Organisational Development is invited to attend meetings to assist with committee business.
Principal activities during the year	The committee considered NHS England Board and board committee composition, recommending changes for Board approval where necessary, received updates on NED recruitment, and reviewed and advised on succession plans for national directors.

Members	Number of eligible meetings attended	Comment
Richard Meddings	3/3	Chair of NHS England
Sir Andrew Morris	3/3	Deputy Chair, NHS England
Wol Kolade	3/3	Deputy Chair, NHS England
Michael Coupe	3/3	Non-Executive Director
Amanda Pritchard	3/3	Chief Executive Officer

Data, Digital and Technology Committee (DDaTC)

Role	The role of the committee is to consider and make recommendations on the digital and technology strategy, including cyber strategy, to the Board and oversee its implementation. It advises on the development of data and technology architecture and assures the Board on the discharge of data functions, including compliance with statutory guidance on protecting patient data.
Frequency	The committee met five times in the financial year.
Membership	The committee is made up of four NEDs, the Chair of NHS England, one Associate NED and three non-executive members. Additional attendees are routinely invited to attend meetings to assist with committee business.
Principal activities during the year	The committee supported a wide range of strategic initiatives, including the rollout of the FDP, strengthening technical architecture, and efforts to address digital and data challenges in primary care. The committee endorsed the Tech and Digitally Enabled Productivity Plan and contributed to shaping the NHS 10-Year Health Plan through development of the data, digital and technology vision and roadmap. It also reviewed the resilience plan and data, digital and technology operating model aimed at enhancing system sustainability and robustness.

Members	Number of eligible meetings attended	Comment
Mark Bailie (Chair)[77]	5/5	Non-Executive Director
Richard Meddings[78]	5/5	Chair of NHS England
Mark Walport	3/5	Non-Executive Director
Michael Coupe	4/5	Non-Executive Director
Robert Lechler	3/5	Non-Executive Director
Suresh Viswanathan	3/5	Associate Non-Executive Director
Steve Woodford	5/5	Non-Executive Member
Daniel Benton	5/5	Non-Executive Member
John Noble[79]	1/1	Non-Executive Member
Jamie Saunders[80]	4/4	Non-Executive Member

[77] Mark Bailie was appointed Chair of the DDaTC in August 2024
[78] Richard Meddings was Chair of the DDaTC until July 2024.
[79] John Noble's term as non-executive committee member ended in July 2024.
[80] Jamie Saunders term as non-executive committee member began on the 1 July 2024.

Quality Committee

Role	The primary role of the committee is to support the Board in ensuring that areas concerning patient safety, the quality of care provided to patients and patient experience are continuing to improve and develop to meet the needs of patients in England.
Frequency	The committee met five times in the financial year.
Membership	The committee is made up of the Chair of NHS England, four NEDs, six National Directors and up to four Patient and Public Voice (PPV) members. Additional attendees are routinely invited to attend meetings to assist with committee business.
Principal activities during the year	The Quality Committee oversaw the development of an Integrated Quality Report and contributed to the development of an NHS Quality Strategy. The committee received updates on issues and challenges in a number of clinical programmes including; Maternity and Neonatal, Children and Young People, Palliative and End of Life care, Stroke, and Learning Disability and Autism. The committee also reviewed all risks relating to quality of care and patient safety on the risk register, ensuring appropriate mitigations are in place. Members reviewed and approved the updated policy on Working with People and Communities, ahead of Board approval.

Members	Number of eligible meetings attended	Comment
Professor Sir Robert Lechler (Chair)[81]	4/5	Non-Executive Director
Professor Sir Simon Wessely (Interim Chair)[82]	3/5	Non-Executive Director
Richard Meddings	5/5	NHS England Chair
Sir David Behan[83]	1/2	Non-Executive Director
Professor the Baroness Mary Watkins[84]	1/1	Non-Executive Director
Dr Aidan Fowler	5/5	National Director of Patient Safety
Emily Lawson[85]	4/5	Chief Operating Officer
Sir Andrew Morris	3/5	Non-Executive Director
Dame Ruth May[86]	0/2	Chief Nursing Officer
Duncan Burton[87]	2/3	Chief Nursing Officer for England
Professor Sir Stephen Powis	4/5	National Medical Director
Amanda Doyle	3/5	National Director for Primary Care and Community Services
Charlotte McArdle[88]	2/4	Deputy Chief Nursing Officer
Andrea Lewis[89]	1/1	Interim Deputy Chief Nursing Officer
Patient and Public Voice members	4/4	

[81] Professor Sir Robert Lechler was appointed Chair of the Quality Committee in September 2024.
[82] Professor Sir Simon Wessely was interim Chair of the Quality Committee until August 2024.
[83] Sir David Behan left the NHS Board on 31 August 2024.
[84] Professor the Baroness Mary Watkins became a member of the Quality Committee in March 2025.
[85] Sarah Jane Marsh (National Director of UEC and Deputy Chief Operating Officer) attended the Quality Committee on behalf of the Chief Operating Officer (5/5).
[86] Dame Ruth May was a member until 24 July 2024.
[87] Duncan Burton was appointed a member on the 25 July 2024.
[88] Charlotte McArdle left the organisation in December 2024.
[89] Andrea Lewis was appointed a member in March 2025.

People and Remuneration Committee

Role	The committee supports the Board in ensuring that NHS England as an employer has appropriate people and workforce strategies in place and is delivering these, provides assurance to the Board on NHS England's workforce risks and oversees strategic people management and organisational development. It also oversees and determines appointment, and remuneration matters in respect of NHS England employees, ICBs and NHS trusts on behalf of the Board. The exercise of these duties and powers is supported by the Executive HR Group, Appointment Termination Committee and Regional Appointment and Approval Committees, which were established by the People and Remuneration Committee.
Frequency	The committee met five times in the financial year.
Membership	The committee is made up of four NEDs and the Chair of NHS England. Additional attendees are routinely invited to attend meetings to assist with committee business.
Principal activities during the year	The committee oversaw significant activity across the People Programme, with a focus on progressing delivery priorities for the newly formed NHS England. This included improving HR services and driving organisational development, culture, and behaviours. The committee reviewed progress on the implementation of the Equality, Diversity and Inclusion Improvement Plan, including work on social mobility and publication of the 2023 Gender Pay Gap report. It also considered updates on staff survey outcomes and internal FTSU activity. Key decisions were made on the revised Appointment Policy for NHS Chairs and NEDs, the proposed pay award for executive and senior medical leaders, and the Board Member Appraisal Framework. The committee continued to oversee Chair and NED talent pipelines, succession planning and senior appointments, while receiving regular updates from the Executive HR Group on pay cases, redundancies, and legal matters.

Members	Number of eligible meetings attended	Comment
Sir David Behan (Chair)[90]	2/2	Non-Executive Director
Jane Ellison (Chair)[91]	5/5	Non-Executive Director
Richard Meddings	3/5	Chair of NHS England
Sir Andrew Morris	3/5	Non-Executive Director
Professor the Baroness Watkins	4/5	Non-Executive Director

[90] Sir David Behan was chair of the People and Remuneration Committee until July 2024.
[91] Jane Ellison was appointed as chair of the People and Remuneration Committee in August 2024.

Workforce, Training and Education Committee

Role	The committee's role is to have oversight of all functions that ensure the NHS in England has a workforce with the capacity, knowledge, skills, values and behaviours to deliver compassionate, high-quality health and care to the people it serves. The committee's work plan ensures that the functions above are aligned to delivering the LTWP and vision for the NHS workforce: more people, working differently, in a compassionate and inclusive culture.
Frequency	The committee met six times in the financial year.
Membership	The committee is made up of at least five NEDs, one Associate NED, and three non-executive members. Additional attendees are routinely invited to attend meetings to assist with committee business.
Principal activities during the year	The committee oversaw a workforce, training and education delivery plan that ensured the Board's priorities were informed by the DHSC mandate and the LTWP. It was also assured on delivery of the Workforce, Training & Education (WT&E) delivery plan and of performance across the system against the WT&E priorities for the NHS. Additionally, and in partnership with the ARAC, it considered and provided assurance to the Board on the management of strategic WT&E risks.

Members	Number of eligible meetings attended	Comment
Sir David Behan (Chair)[92]	3/6	Non-Executive Director
Sir Andrew Morris (Chair)[93]	6/6	Non-Executive Director
Professor the Baroness Watkins	5/6	Non-Executive Director
Professor Dame Helen Stokes-Lampard	2/6	Non-Executive Director
Professor Sir Mark Walport	2/6	Non-Executive Director
Dr Harpreet Sood	2/6	Non-Executive Member
John Latham	5/6	Non-Executive Member
Professor Andrew George	5/6	Non-Executive Member
Tanuj Kapilashrami[94]	4/6	Non-Executive Member

[92] Sir David Behan was chair of the Workforce, Training and Education Committee until July 2024.
[93] Sir Andrew Morris was appointed chair of the Workforce, Training and Education Committee from August 2024.
[94] Tanuj Kapilashrami was appointed as a member of the Workforce, Training and Education Committee in June 2024.

The New NHS England Committee

Role	The New NHS England Committee was a time-limited committee, established to provide leadership and strategic oversight of the delivery of the Creating the New NHS England Programme.
Frequency	The committee met once in the financial year. It was disbanded in May 2024 at the close down of the Creating the New NHS England Programme.
Membership	The committee was made up of three NEDs, the Chair of NHS England and three national directors. Additional attendees were routinely invited to attend meetings to assist with committee business.
Principal activities during the year	The only meeting of the New NHS England Committee this financial year oversaw the close down of the programme and transfer of remaining activities. The committee also reviewed lessons learned from the programme.

Members	Number of eligible meetings attended	Comment
Wol Kolade (Chair)	1/1	Deputy Chair, NHS England
Richard Meddings	1/1	Chair of NHS England
Sir Andrew Morris	1/1	Deputy Chair, NHS England
Sir David Behan	1/1	Non-Executive Director
Amanda Pritchard	1/1	Chief Executive Officer
Julian Kelly	1/1	Chief Financial Officer
Steve Russell	1/1	Chief Delivery Officer

The New Hospital Programme (NHP) Delivery Committee

Role	The NHP Delivery Committee's role is to scrutinise, challenge and assure delivery of the NHP on behalf of the Board.
Frequency	The committee met four times in the financial year.
Membership	The committee is made up of the Chair of NHS England, two NEDs, three national directors, the Chief Programme Officer, and two independent advisors. Additional attendees are routinely invited to attend meetings to assist with committee business.
Principal activities during the year	The committee endorsed the NHP agreement, which formalises the relationship between partners (NHP, NHS England, and relevant NHS provider organisations) in the delivery of the NHP Programme. It also received updates on the Hospital 2.0 system, a central programmatic delivery strategy for the NHP, and programme risks and mitigations.

Members	Number of eligible meetings attended	Comment
Richard Meddings	4/4	Chair, NHS England
Wol Kolade	4/4	Deputy Chair of NHS England
Michael Coupe	4/4	Non-Executive Director
Julian Kelly	2/4	Chief Financial Officer
Amanda Pritchard	0/4	Chief Executive
Jacqueline Rock[95]	3/3	Chief Commercial Officer
Morag Stuart	4/4	Chief Programme Officer, the New Hospital Programme
Independent Advisers	4/4	

[95] Jacqueline Rock left the organisation in December 2024.

Board disclosures

Functional conflicts

NHS England maintains a policy on conflicts between functions, to comply with its duty under new section 13SB of the National Health Service Act 2006 (inserted by section 34 of the Health and Care Act 2022), to make arrangements to minimise the risk of conflicts between the exercise of the former Monitor regulatory functions and NHS England's other functions, and to manage any conflicts that arise. The policy contains arrangements for handling individual conflicts (notifiable to the Board Secretariat) and provides for formal escalation to a non-executive panel. The need to mitigate functional conflicts was considered as part of the setup of the Independent Patient Choice and Procurement Panel, where there are conflicts checks at each panel meeting and when panel members are allocated to cases. During 2024/25, the Board Secretariat were notified of no (zero) conflicts.

Register of Board members' interests

Personal interests held by Board and committee members are managed in accordance with the NHS England Standing Orders and the Standards of Business Conduct policy. The organisation maintains a register of members' interests to ensure that potential conflicts of interest can be managed appropriately. Board members and executives are also required at the beginning of each Board and committee meeting to declare any personal interest they might have in any business on the agenda and abstain from relevant Board or committee discussions as required. Where potential conflicts arise, they are recorded in the Board and committee minutes along with any appropriate action to address them. A copy of the register of interests is available on our website. Note that this only reflects Board members currently in post.[96]

Details of related party transactions, where NHS England has transacted with other organisations during the year to which a Board or an executive is connected, are set out in Note 19 on page 171.

Disclosure of personal data breach incidents

For the disclosure of personal data breach incidents, NHS England follows the Data Security and Protection Toolkit (DSPT) Incident Reporting process guidance. This is in line with the UK General Data Protection Regulation (UK GDPR). The DSPT sets out the reporting requirements for NHS organisations where a potential or actual incident may lead to a personal data breach as defined under UK GDPR. All organisations that have access to NHS patient data and systems must use DSPT to provide assurance that they are practising good data security, and where required under UK GDPR, to report a personal data breach to the Information Commissioner's Office (ICO).

In 2024/25, NHS England reported 246 personal data breaches to the Data Protection Officer. 10 of these were reported to the ICO voluntarily or where they met the threshold for reporting under UK GDPR.

[96] https://www.england.nhs.uk/publication/our-board-members-register-of-interests

Directors' third-party indemnity provisions

NHS England has the appropriate director's and officer's liability indemnity in place for legal action brought against, among others, its executive and NEDs, by virtue of its membership of the statutory Liabilities to Third Parties Scheme administered by NHS Resolution.
During 2024/25, there was one ongoing legal claim brought against NHS England during 2022/23 (disclosed in our prior year report), concerning alleged conduct of an NHS England director. This claim was indemnified by NHS Resolution.

Directors' responsibility statement

The Annual Report and Accounts have been reviewed in detail by NHS England's ARAC and Board. At each point it has been confirmed that the Annual Report and Accounts, taken as a whole, are considered to be fair, balanced, and understandable. They provide the information necessary for NHS England's stakeholders to assess the business model, performance, and strategy.

Human rights

NHS England supports the Government's objectives to eradicate modern slavery and human trafficking. The NHS England Slavery and Human Trafficking Statement for the financial year ending 31 March 2025 is available on our website.[97]

[97] https://www.england.nhs.uk/long-read/modern-slavery-guidance-and-annual-statement/

Statement of Accounting Officer's responsibilities

Under the National Health Service Act 2006 (as amended), the Secretary of State for Health and Social Care (with the consent of HM Treasury) has directed NHS England to prepare, for each financial year, a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of NHS England and of its income and expenditure, statement of financial position and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Government Financial Reporting Manual (FreM)[98] and in particular to:

- observe the Accounts Direction issued by the DHSC, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards, as set out in the Government FReM, have been followed and disclose and explain any material departures in the financial statements
- prepare the financial statements on a going concern basis
- confirm that the Annual Report and Accounts are fair, balanced, and understandable, and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that they are fair, balanced and understandable.

The National Health Service Act 2006 (as amended) schedule A1 paragraph 15(4) states that the Chief Executive shall be the Accounting Officer of NHS England.

The responsibilities of the Accounting Officer, including responsibilities for the propriety and regularity of the public finances for which the Accounting Officer is answerable and for keeping proper records and safeguarding NHS England's assets are set out in Managing Public Money (HM Treasury, July 2013, as amended May 2023).[99]

As the Accounting Officer for NHS England, I have taken the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS England's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

I confirm that there was adequate and sufficient handover from the previous Accounting Officer to provide me with the assurances required to make these statements.

[98] https://www.gov.uk/government/publications/government-financial-reporting-manual-2024-25
[99] https://www.gov.uk/government/publications/managing-public-money

Governance statement

This governance statement covers NHS England, its system leadership role of the NHS, directly commissioned health services, and oversight and assurance of the commissioning system.

Following the government's announcement in March 2025, NHS England will undergo significant structural reform as part of the wider 10-year health plan to build an NHS fit for the future. The organisation's functions will be streamlined and integrated into the DHSC to reduce bureaucratic duplication, both nationally and at ICB level. This restructuring is designed to eliminate operational inefficiencies and redirect substantial resources - potentially amounting to hundreds of millions of pounds - towards frontline patient services. This structural transformation represents part of broader healthcare reforms that are necessary to address the critical challenges facing the NHS and ensure its long-term sustainability.

As Accounting Officer, I have responsibility for the system of internal controls supporting and enabling the achievement of NHS England's aims and objectives, while safeguarding public funds and the assets for which I am personally responsible in accordance with Managing Public Money and as set out in my Accounting Officer appointment letter.

This includes assurance of several organisations which are part of the wider commissioning system, including those organisations hosted by NHS England.

My responsibilities in relation to the oversight of ICBs are set out from page 74.

Board arrangements

Information on our Board and its committees is set out from page 55.

Freedom to Speak Up

Our report on whistleblowing disclosures made by NHS workers is published on our website.[100]

Government functional standards

Functional standards[101] set out what needs to be done, and why, for different types of functional work and were mandated for use in Governmental departments and their ALBs from the end of March 2022. The extent to which these standards are adopted across NHS England varies, and certain elements of the standards are not applicable to the organisation.

[100] https://www.england.nhs.uk/ourwork/freedom-to-speak-up/whistleblowing-disclosures/
[101] https://www.gov.uk/government/publications/dao-0521-mandating-functional-standards-from-end-september-2021

Governance arrangements and effectiveness

Governance framework

The Governance Manual brings together all key strands of governance and assurance, including Standing Orders, Standing Financial Instructions (SFIs), Scheme of Delegation, Standards of Business Conduct Policy, Risk Management Framework and the three lines of defence model.

Assessment against the Corporate Governance in Central Governance Departments: Code of Good Practice 2017 Compliance Checklist

As part of implementing best practice, an assessment is undertaken each year against this checklist from HM Treasury. NHS England is compliant[102] against the provisions of the code, with the following exceptions:

Ref	Code provision	Exception
4.7	Through the Board Secretariat, the Department provides the necessary resources for developing the knowledge and capabilities of Board members, including access to its operations and staff	This responsibility is shared between the Chair, the Chief Executive's private office and the Board Secretary
4.11	The Board Secretary's responsibilities include arranging induction and professional development of Board Members	This responsibility is shared between the Chair, Chief Executive's private office and the Board Secretary
4.12	The lead non-executive board member supports the chair to ensure a board effectiveness evaluation is carried out annually, and is carried out with independent input at least once every three years,	Effectiveness evaluation takes place annually, due to organisational changes independent input has not been sought in the last three years
5.5	The Head of Internal Audit is periodically invited to attend Board meetings, where key issues are discussed relating to governance, risk management, or control issues across the department and its ALBs	The Head of Internal Audit routinely attends ARAC meetings

[102] It should be noted that the following provisions in the code do not apply to NHS England: Sections 1, 2.3, 2.11, 3.3a, 3.3b, 3.3c, 3.6e, 3.7, 3.8, 3.9, 3.14, 3.19, 4.9, 4.12, 4.13, 4.14, 5.7, 5.8 and 6.

Corporate assurance

The NHS England corporate assurance framework, set out below, helps to provide assurance on organisational stewardship and the management of significant risks to organisational objectives.

Assurance activity	How does it add value?
Organisational change framework Guidelines for assessing and implementing major changes across the organisation.	The framework provides a consistent approach to thinking about the impact of organisational change, including on people, infrastructure, financial and legal issues.
Risk management framework Our approach to managing risk, including tools and methodologies for identifying, assessing, documenting and reporting risk.	The framework enables a consistent approach to be taken across the organisation, allowing identification of cross-directorate risks and challenges. It provides a mechanism for managers to identify risks with a route of escalation to those accountable.
SFIs, Scheme of Delegation and Standing Orders These documents protect both the organisation's interests and officers from possible accusation that they have acted less than properly.	Together, these documents ensure that our financial transactions, accountabilities and responsibilities are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.
Programme management framework The policies, tools, methodology and resources that provide an approach to managing, controlling and assuring the delivery of projects and programmes in the organisational portfolio.	Provides staff with a framework to manage, control and deliver projects and programmes. Provides the organisation with consistency of reporting and monitoring, confidence of delivery of outcomes to enable decision-making and better resource control.
Contract management framework Guidelines for the assurance required for managing third-party contracts.	Ensures directorates responsible for major contracts assign a contract manager and put arrangements in place to monitor supplier performance. Obtains assurance over the services provided.
Corporate policy framework The methodology and approach for creating, maintaining and amending policies.	Provides an approach to help ensure policy documents are not developed in isolation, so they are balanced against the priorities of the organisation.

We work with the support of both our internal and external auditors to strengthen and embed our assurance framework. All directorates and regions have designated leads with responsibility for ensuring that risk management, implementation of internal audit actions and other key assurance activities are properly carried out, including regular reporting and escalation.

During 2024/25, the corporate governance and compliance teams worked across the organisation to improve and embed controls by:

- ensuring that officers declared relevant interests in line with the Standards of Business Conduct Policy
- developing refreshed strategic and operational risk registers (ORRs)
- introducing enhanced risk governance arrangements to support the management of our most significant risks
- carrying out targeted interventions with teams to ensure the timely completion of actions arising from internal audit reviews
- developing and implementing an approach to undertake assurance reviews against NHS England's statutory functions.

Management assurance

Throughout 2024/25, the Board has been provided with regular performance updates on the implementation of the priorities and programmes committed to in the NHS Long Term Plan and NHS England's business plan.

Board reporting integrates performance against constitutional standards, the NHS Long Term Plan commitments and workforce and quality metrics.

Individual programme boards and oversight groups, each with responsibility for delivery of their programmes, meet frequently, with representatives from national and regional teams.

Assuring the quality of data and reporting

The Board has agreed the information it requires to carry out its duties. The Board is confident that performance reports have been through appropriate management review and scrutiny, and that reporting continues to evolve to meet changing organisational needs.

Risk governance

The Board sets the organisation's risk appetite and oversees the organisational risk profile to ensure key risks are mitigated within the agreed appetite level. Risk appetite statements, setting out the amount of risk that we are willing to seek or accept in the pursuit of long-term objectives, were approved in May 2024. The Board discusses the most significant risks and actions identified to mitigate their likelihood and impact.

ARAC is responsible for reviewing the establishment and maintenance of an effective system of risk management. The committee holds the organisation to account on the effectiveness of risk management processes and evaluates the effectiveness of the Risk Management Framework. It oversees the risk governance activities undertaken by the executive and board committees which consider those strategic risks, and top operational risks, that fall under their remit.

Executive committees are responsible for assessing and challenging the effectiveness of risk mitigation plans, ensuring relevant actions are implemented and escalating as appropriate to the NHS Executive. Board committees seek assurance, including through periodic deep dives,

that risks are being effectively mitigated or have adequate plans in place where the current risk score is not within appetite.

Executive Risk Group is responsible for assuring ARAC about how risks across the organisation are being managed in line with the Risk Management Framework. The NHS Executive also periodically reviews the organisation's most significant risks and, when appropriate, undertakes in-depth review.

The Chief Executive Officer, supported by senior management, provides leadership, and articulates their continued commitment to risk management through the organisational risk management framework.

The executive team collectively owns the Strategic Risk Register (SRR) and ORR and has nominated a responsible officer for each risk within them. Individual executives are responsible for managing risk at a directorate and regional level. Each directorate and region hold its own risk register and is required to regularly review its risks.

Recognising that changing leadership, with a resultant loss of corporate memory and the potential for this to continue as posts are appointed to the new organisation, may have an adverse impact on decision making, accountability or cross-team working. ARAC requested that this risk be considered and added to the ORR. Key controls and mitigations for this risk include: frequent executive meetings to support decision-making; inter-organisational collaboration ensures governance clarity; a governance manual outlining decision-making powers; and a revised terms of reference define responsibilities.

Principal risks

The SRR and ORR together contain over 40 risks to the organisation. The SRR considers the principal risks that could impact delivery of NHS England's strategic objectives. The ORR contains the key organisational risks which relate to systems, processes and in-year delivery. NHS England's risk profile changes throughout the course of the year in response to events and emerging priorities. NHS England considers its most significant risks to be those which, once mitigated as far as possible, will remain outside of risk appetite. The five risks detailed below were NHS England's most significant risks in 2024/25 and will remain under regular review.

Risk: The NHS workforce is not sufficiently skilled or resourced to meet the immediate or future needs of the population.

This includes gaps in skill mix, rising demand, and ongoing challenges in culture, training, and retention. The LTWP was developed to address these issues. However, several planned mitigations have been affected by a change in government direction and funding constraints. As a result, the workforce capacity risk remains high.

A broad range of controls have been implemented under the LTWP to mitigate this risk. These include regional pilots of generalist training models, introduction of new roles such as anaesthetic and physician associates, and greater use of digital tools, supported by initiatives like the NHS Digital Academy. To address rising demand, measures have included increased

medical school places, targeted international recruitment, and successful delivery of the 50k nursing recruitment target ahead of schedule. Retention has been supported through programmes such as the People Promise exemplar sites and publication of the NHS Equality Diversity and Inclusion Improvement Plan. Governance tools, including the Education Quality Assurance Training Framework and Board-level competency frameworks, have also been established.

Several key milestones originally planned to reduce the risk have not been met. These include the confirmation of apprenticeship funding and the commencement of the Medical Doctor Degree Apprenticeship pilot. The Digital Staff Passport was delayed beyond December 2024 as part of a broader prioritisation review. While the People Promise Exemplar Programme continues to roll out, current data does not yet show sustained improvement. Delays to these milestones—largely due to factors outside NHS England's control—present a challenge to effective risk reduction. The LTWP is now under review 18 months after publication, with many mitigations yet to be delivered. Delivery plans for other elements of the LTWP are currently in development and will inform future assessments of the risk score once implementation is underway.

Risk: There is a risk to quality care (safety, effectiveness and experience) for patients, carers and families if NHS England does not satisfactorily deliver its statutory functions; commissioning and regulatory duties; implement national policy and strategy that cover assurance, improvement and planning functions.

Due to the cross-cutting nature of quality, assurance and evaluation of this risk occur within the governance of existing programmes, such as the implementation of the Patient Safety Strategy.

A comprehensive set of controls is in place to manage this risk. These include the continued investigation of unsafe care, and implementation of the National Patient Safety Strategy and associated policies, such as Martha's Rule and initiatives on managing deterioration. NHS England has established clear governance structures and escalation processes, including a revised National Quality Board (NQB) framework, and effective learning mechanisms from coroners' reports and safety incidents. Work on patient experience has also been prioritised, and public and patient involvement is embedded across programmes. Additionally, national and regional quality and safety teams are in place to support delivery and oversight.

Ongoing mitigation focuses on the development and implementation of a Quality Strategy for the NHS, led by the NQB and aligned with the 10-Year Health Plan and the Dash Review of Quality. This will encompass quality management systems, patient safety, experience, and clinical effectiveness. Planned work includes publication of the Quality Strategy, improvements to internal quality governance structures, and reconstitution of the NQB with updated terms of reference and governance routes. Further action includes development of a quality dashboard, updates to clinical audit governance, and publication of new guidance on QIA and best practice for audits. Efforts are also underway to ensure appropriate resources, expertise, and clarity of roles are in place to support and embed quality across the system.

Risk: There is a risk of national supply disruption in the supply market of non-clinical goods, services, medical devices and clinical consumables; amplified supply chain fragility due to a variety of factors including geopolitical, global economic challenges, cyber threats, lack of processes and capacity to proactively anticipate and manage supply challenges, could have potential adverse consequences for patient outcomes.

Immediate responses to incidents are often effective at preventing short-term harm, however they come at high cost and offer limited support for longer-term patient safety or systemic resilience. In response, an expert working group was convened in November 2024 with cross-organisational stakeholders to assess the resilience landscape, map gaps, and develop a more coordinated approach to risk management.

Several controls are currently in place. The DHSC and NHS Supply Chain manage supply disruptions through structured mechanisms such as the Shortage Management Oversight Group and the use of data tools. NHS Supply Chain has demand management processes and maintains oversight of products in their catalogue, although this only covers around 60% of the NHS market. Clinical expertise is available during incident response, though gaps in resource capacity are recognised. Additional control measures include contingency logistics such as air freight and expedited freight services, compliance with legislation through contract management, and horizon scanning for regulatory changes.

Areas identified for further attention include high-risk categories such as digital, estates, independent sector provision, pharmaceutical devices, and transport. Key next steps include establishing robust clinical and commercial expertise, improving proactive communication with trusts and ICBs, and defining national leadership on supply resilience.

Risk: Due to advancements in technology and improved care pathways, 45% of estates infrastructure (including reinforced autoclaved aerated concrete) is not fit for the services the NHS delivers today. This results in disruption to productive clinical services, significant risks to patient and staff safety and an estate that is located in places not aligned with the populations needs.

While key strategies such as the Long-Term Infrastructure Strategy and Integrated Care Systems (ICS) Estate Strategies are underway, financial and capacity constraints are affecting progress. Work on a supplier resilience strategy has been paused, and some planned developments are delayed or under-resourced, impacting the pace of change.

Infrastructure strategies led by ICBs aim to align estate needs with service models. A Property Companies Delivery Board has been established to coordinate delivery and maximise the NHS property offer. National oversight is improving, supported by the Capital Strategy Programme and ICS Infrastructure work. Early steps are being taken to build an asset management centre of excellence and improve estate guidance. A workforce action plan has been delivered, though it does not yet address structural capability or pay disparities.

Work is ongoing with ICSs to develop first-generation infrastructure and investment strategies, focused on creating an estate that is resilient, efficient, and better aligned with service delivery. Key deliverables include a Primary Care Estates Strategy, a Supplier Resilience Strategy and

an Operational Digitalisation Strategy. Some workstreams are paused due to lack of financial support. The publication of an Asset Management Strategy and updated Estate Code is now expected in June 2025.

Risk: There is a risk of significant data breach resulting in accidental or unlawful loss, alteration, unavailability, unauthorised disclosure of, or access to, personal data causing patient and employee harm, poor clinical outcomes, damage to public trust, lost productivity and financial loss.

Given NHS England's role as a custodian of some of the world's most comprehensive and sensitive health and workforce data, the impact of a breach could be severe, affecting patients, staff, public trust, clinical outcomes, and leading to productivity loss and financial damage. The greatest severity of breach would likely result from a cyber-attack, insider threat, or supply chain failure, risks where NHS England has only partial control.

A comprehensive governance framework is in place to ensure appropriate technical, organisational, and security controls. This includes policies and training for records management, data protection by design, and mandatory Data Protection Impact Assessments (DPIAs). Awareness campaigns and training reinforce staff responsibilities and breach response procedures. Breach incidents are actively monitored and investigated by a dedicated team, with 24/7 response capacity and breach-specific playbooks. Legal and regulatory processes are embedded, with external legal support and stakeholder coordination including the ICO. A strong lessons-learned feedback loop ensures that breach causes are analysed, trends identified, and actions taken to reduce recurrence. Information Governance (IG) audits and monitoring support assurance and compliance across the organisation.

Key future deliverables include a breach cause analysis process, and refreshed IG policies including those on Generative AI and international data transfers. IG audit procedures will be implemented to monitor compliance, alongside breach assurance reviews. However, ongoing resource constraints may delay or prevent delivery of several mitigation actions including additional incident capacity, creating a risk of insufficient capacity in the event of multiple data breaches. Further IG awareness activities are planned, with internal campaigns ongoing through 2025/26.

NHS oversight and support

We use the NHS Oversight Framework to assess ICBs' and providers' performance against a set of metrics and allocate them into one of four segments, which determine the level of support we provide. NHS England has met regularly with each ICB throughout the year, to review segments and support needs for both the ICB and the providers across their ICS footprint and published segmentation decisions on our website.

To ensure the model of oversight remains relevant and effective we committed in the 2024/25 Priorities and Operational Planning guidance to engage on a new oversight framework. We formally consulted on the principles underpinning our oversight approach in spring 2024 and have engaged with service leaders and the new government to develop an NHS Oversight

Framework[103] in line with the government's 2025 Mandate to NHS England. A draft of this framework underwent public consultation early in 2025/26. We intend to publish the first formal segmentation decisions in quarter two, giving a segment score of 1-4 based on performance against delivery metrics.

Quality oversight and assurance

NHS England understands the importance of viewing quality, finance, workforce and population health matters together as part of the Quadruple Aim, and of managing quality through a combination of planning, improvement, control and assurance activity (a Quality Management System approach).

NHS England develops the strategy for and delivers a range of statutory quality functions, including the NHS Patient Safety Strategy, the National Clinical Audit Programme, the Safeguarding Accountability and Assurance Framework, NICE Guidelines and Quality Standards, Coroners Prevention of Future Death reports, Freedom to Speak Up, Professional Standards and complaints.

The Board's Quality Committee (see page 59) ensures that NHS England's strategies are continually improving quality, safety, and experience of care. Executive level quality meetings reporting in are the Quality and Performance Committee to scrutinise quality, performance, workforce and finance issues, and the Executive Quality Group to provide oversight and scrutiny of care quality across regions and receives regional quality insight from ICBs and providers.

Provider collaboratives

NHS England has supported providers to continue to strengthen collaborative arrangements as part of ICSs, to deliver improvements and transform care for patients. The spread of best practice has been encouraged through the delivery of a programme of support – including webinars, case studies, and peer learning. Collaboratives are increasingly leading on key improvement priorities on behalf of the wider system, such as elective care performance, clinical support services, and corporate efficiencies.

Alongside provider collaboratives, shared chair and chief executive arrangements have been put in place across some NHS trusts and foundation trusts where this enables more effective collaboration. NHS England has worked with trusts to understand the opportunities and risks of such arrangements.

Regulating independent providers of NHS services

All independent providers of NHS services are required to hold a provider licence, unless exempt, under the DHSC regulations. The provider licence gives NHS England the ability to safeguard continuity of services for patients if a provider gets into difficulty. As of 31 March 2025, 150 independent providers held a provider licence, as did three NHS-controlled providers.

[103] https://www.england.nhs.uk/long-read/nhs-oversight-framework-2025-26/

Under the ‘Commissioner Requested Services’ policy; local commissioners are required to tell NHS England which of their services (commissioned from independent providers) need the protections of the licence’s continuity of services conditions. Under the ‘Hard to Replace Providers’ policy, NHS England can apply the same protections where providers deliver regional or national services of significant scale or complexity. As of 31 March 2025, 55 licensed providers were subject to the license’s continuity of services conditions.

During 2024/25, no formal enforcement action was taken with any independent providers, meaning that as of 31 March 2025, no enforcement undertakings were in place.

Mergers and acquisitions

NHS England is responsible for risk rating statutory transactions. The assurance process for significant transactions includes reviewing trusts’ strategic cases and full business cases to assess the rationale for the transaction, why the transaction is the preferred option, the likely financial and patient benefits associated with the transaction, that the transaction and integration is well planned and that all statutory requirements have been met. These are assessed through review of documentation and discussions with the trusts, ICBs and system leaders.

Transactions completed during the reporting period:

- Transfer of services (community, mental health and learning disability) from Isle of Wight NHS Trust to Southern Health NHS Foundation Trust on 1 May 2024.
- Southern Health NHS Foundation Trust acquired Solent NHS Trust on 1 October 2024, with the newly enlarged trust renamed Hampshire and Isle of Wight Healthcare NHS Foundation Trust.
- Transfer of services and dissolution of Dudley Integrated Health and Care NHS Trust on 1 October 2024.
- Kingston Hospital NHS Foundation Trust acquired Hounslow and Richmond NHS Trust on 1 November 2024, with the newly enlarged trust renamed Kingston and Richmond NHS Foundation Trust.
- Camden and Islington NHS Foundation Trust acquired Barnet, Enfield and Haringey NHS Trust 1 November 2024, with the newly enlarged trust renamed North London NHS Foundation Trust.
- Royal Free London NHS Foundation Trust acquired North Middlesex University Hospital NHS Trust on 1 January 2025, with the newly enlarged trust retaining the Royal Free London NHS Foundation Trust name.

New Hospitals

Three new hospitals were opened through the New Hospital Programme, including the Dyson Cancer Centre (Royal United Hospitals Bath NHS Foundation Trust), the Greater Manchester Major Trauma Hospital (Northern Care Alliance NHS Foundation Trust) and the Midland Metropolitan University Hospital (Sandwell & West Birmingham Hospitals) opened during 2024/25.

Direct commissioning by NHS England and delegation to ICBs

NHS England directly commissions certain clinical services at a national or regional level. During 2024/25, NHS England continued to delegate the responsibility for commissioning suitable services to ICBs, to realise the benefits of integrated commissioning at local level, including improving population health outcomes, reducing health inequalities and achieving better value for money. Where NHS England has delegated responsibility to ICBs for commissioning services, NHS England remains accountable for these services. During the year, a single approach to oversight and assurance of delegated commissioning has been developed, ready to apply to primary care and specialised services in 2025/26, and to any more commissioning services subsequently delegated.

Primary care services

In 2024/25, NHS England followed its Primary Care Commissioning Assurance Framework to oversee ICBs' delegated commissioning of primary care services (primary medical, dental (primary, secondary and community), general ophthalmic and pharmaceutical services). Overall, this exercise indicated full or substantial assurance for 35 out of 42 ICBs across all their primary care functions. For the remaining ICBs, there were some individual functions where there was limited evidence, and these were subject to additional assessment and agreed actions where required.

Specialised services

Specialised services support people with a range of rare and complex conditions. They often involve innovative treatments for patients with rare cancers, genetic disorders, complex medical conditions or surgical needs. The specialised commissioning allocation for all specialised services was £27 billion at the end of 2024/25.

In April 2024, commissioning responsibility for 59 specialised services was delegated to all ICBs in the Northwest, Midlands, and East of England regions. ICBs in the remaining regions continued to commission these services via five statutory joint committees, formed between ICB and NHS England regions. Most of the £27 billion allocation is issued to ICBs for delegated services and regional teams for jointly commissioned and retained specialised services, with the balance held centrally to fund national budgets such as the Cancer Drugs Fund and other national programmes. Local ICB governance structures and annual reporting applies to the £5.6 billion spend allocated to ICBs in Northwest, Midlands, and East of England ICBs, in their duty as responsible commissioners.

NHS England acted as the accountable commissioner for both delegated and retained services, maintaining oversight through regional accountability reporting lines. During 2024/25, the Delegated Commissioning Group for Specialised Services continued to provide strategic direction for the 59 delegated services, set national standards, approved key national transformational gateway documents, and brought together the responsible and accountable commissioners from across the country. Correspondingly, the National Commissioning Group for Specialised, Health and Justice Armed Forces Services continued to set strategic direction,

set standards and manage gateway approvals, as well as oversee commissioning of those services commissioned by NHS England.

The Clinical Priorities Advisory Group made formal recommendations relating to the commissioning treatments and interventions for adoption across delegated and retained services.

In 2024/25, there was careful assessment and preparations for all suitable specialised services (including an additional 11 services, thus 70 services in total) to be delegated to all ICBs in England, commencing in April 2025.

Health and justice

Health and justice services comprise health services in adult prisons and pre and post custody services, IRC's, children and young persons secure and detained and sexual assault referral centres. They are supported through the Health and Justice Delivery and Oversight Group nationally, and this feeds into the NCG. NHS England regional teams are the responsible commissioners for health and justice services, working in conjunction with the appropriate national health and justice teams.

Armed forces

Armed Forces directly commissioned services comprise secondary and community care for serving personnel and some families; prosthetics and three bespoke physical and mental health services for veterans. They are the responsibility of the national armed forces commissioning team. This is overseen by the Armed Forces Oversight Group which feeds into the NCG.

Vaccinations and screening – governance and the Section 7A agreement

The annual NHS Section 7A public health functions agreement between NHS England and the DHSC sets out the arrangements under which the Secretary of State delegates responsibility to the NHS England Board for commissioning certain NHS public health services. Under that agreement, NHS England commissions 11 screening programmes, 20 immunisation programmes, and Child Health Information Services (CHIS).

Internal assurance in 2024/25 was provided through the NHS England Vaccinations and Screening Delivery and Transformation Board, informed by programme-specific boards for screening, vaccinations, and CHIS programmes.

In January 2025, following extensive engagement with ICBs and other stakeholders, the NHS England Board approved the delegation of the commissioning of all vaccination services and most screening services, to take place in April 2026 (subject to Ministerial approval and readiness). Following the organisational changes subsequently announced, commissioning accountability for vaccination and screening will now transfer to ICBs. This is likely to take place from April 2027, subject to the passage of legislation.

Other assurance

Information Governance

The Privacy, Transparency & Trust (PTT) function provides operational data protection, confidentiality and records management advice and support to enable NHS England to meet data protection requirements, minimise privacy and confidentiality risks, manage corporate records, respond to, investigate and report personal data breaches[104], and improve transparency over how NHS England uses data. The PTT function also delivers services that support other NHS organisations with IG.

In 2024/25, the PTT function has delivered advice, support and services that have enabled NHS England to:

- deliver national digital, technology and data products, platforms and services to other parts of the NHS e.g. NHS App, NHS Mail, FDP, NHS Notify, National Proxy
- support other NHS organisations to respond to cyber incidents, including supporting the NHS response to the attack on Synnovis, a laboratory service provider in 2024
- collect, analyse, use and share national datasets for operational, planning, commissioning and research purposes. This includes supporting seven new Secretary of State directions[105] and two statutory requests[106] (from Digital Health and Care Wales) for the collection and analysis of datasets. Those directions[107] and requests[108] are published on our website
- use data internally, for example in relation to Human Resources, use of internal IT systems and management of records, including publishing a new Operational Selection for Preservation Policy relating to records to be preserved under the Public Records Act 1958 and updates to Data Protection, Confidentiality and Records Management Policies
- respond to individual rights requests made under UK GDPR, including requests for access to personal data. During 2024/25 NHS England responded to 808 data access requests
- provide assurance that it is practising good data security, and that personal information is handled correctly, through its annual submission against the standards set out in the Data Protection and Security Toolkit.[109] All mandatory standards were met in 2024/25.

[104] See Director's Disclosures at page 58
[105] Under section 254 of the Health and Social Care Act 2012
[106] Under section 255 of the Health and Social Care Act 2012
[107] https://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/directions-and-data-provision-notices/secretary-of-state-directions
[108] https://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/directions-and-data-provision-notices/nhs-wales-directions
[109] https://www.dsptoolkit.nhs.uk/

Assessment under section 13U(2)(d) of the National Health Services Act 2006

Under section 13U(2)(d) of the National Health Services Act 2006, the annual report must contain an assessment of how effectively NHS England has discharged its relevant data functions.[110]

NHS England has published information on our website generally[111] about the ways NHS England protects data and has regard to the Statutory Guidance on NHS England's Protection of Patient Data[112] in the discharge of its function. In addition, during 2024/25:

- NHS England established tailored IG arrangements to support the roll out of the FDP. This included the development of the FDP Information Governance Framework[113], DPIA templates for local FDP products, FDP specific DPIAs for national products, a new FDP Privacy Notice[114] and separate national and local Product Privacy Notices.[115] The FDP DPIA was also published.
- NHS England has several de-identified technical data processing environments where de-identified data is analysed to fulfil its statutory functions. Since March 2024 this included the national instance of the FDP which hosts national products which transitioned from the national data platform.
- During 2024/25, a new privacy enhancing technology service was launched within NHS England, which enhances privacy protection through de-identification and treatment of data to support analysis in de-identified data processing environments, including the national instance of the FDP.
- NHS England seeks advice from its Advisory Group for Data (AGD) on specific data access requests and to support the development and maintenance of precedents, standards, and guidance on data access for planning, commissioning and research. The AGD minutes containing advice provided and the AGD Terms of Reference are publicly available on the NHS England website.[116] Recruitment of a new Chair and some new members of AGD to replace members whose terms of appointment came to an end began in 2024/25 and will complete early in 2025/26.
- NHS England regularly consults and engages with the National Data Guardian (NDG) and the ICO. During 2024/25, NHS England had regular engagement with National Data Guardian and ICO in relation to the development of the IG documentation that supports the FDP.[117] A range of other FDP programme specific expert advisory groups also met regularly to support the implementation of the FDP including the FDP Check and Challenge Group and the FDP Data Governance Group.
- NHS England considers that it is effectively protecting patient data and has effectively discharged its relevant data functions during 2024/25.

[110] As defined in section 253(3) of the Health and Social Care Act 2012
[111] https://www.england.nhs.uk/about/protecting-and-safely-using-data-in-the-new-nhs-england/
[112] https://www.gov.uk/government/publications/nhs-englands-protection-of-patient-data
[113] https://www.england.nhs.uk/publication/federated-data-platform-information-governance-framework/
[114] https://www.england.nhs.uk/digitaltechnology/nhs-federated-data-platform/security-privacy/how-we-are-protecting-privacy-and-confidentiality/nhs-fdp-privacy-notice/
[115] https://www.england.nhs.uk/digitaltechnology/nhs-federated-data-platform/security-privacy/ig/national-fdp-products/ and https://www.england.nhs.uk/digitaltechnology/nhs-federated-data-platform/security-privacy/ig/local-fdp-products/
[116] https://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/advisory-group-for-data/advisory-group-for-data-minutes and https://digital.nhs.uk/binaries/content/assets/website-assets/corporate-information/corporate-information-and-documents/advisory-group-for-data/advisory-group-for-data-terms-of-reference-v1.0---final.pdf
[117] https://www.england.nhs.uk/digitaltechnology/nhs-federated-data-platform/security-privacy/ig/

Commissioning support units

Four NHS CSUs operate across England, providing essential support to organisations including ICBs, trusts, NHS England, and local authorities. With a workforce of circa 6,500 and income of circa £450 million, CSUs rely on income for services delivered, creating an incentive to offer quality services and value to the NHS at scale.

As an integral part of the NHS, CSUs operate in accordance with good governance principles. In 2024/25, the CSU programme achieved its financial targets.

Supply Chain Coordination Limited (SCCL)

SCCL is the company owned by NHS England which manages the NHS supply chain. It undertakes its procurement services and transacts with customers and suppliers, leveraging the collective buying power of the NHS to support them to achieve their financial, operational and strategic objectives.

NHS England is the sole shareholder of SCCL, a UK incorporated company. SCCL's Articles of Association include a range of matters reserved for shareholder decision.

NHS England has established a governance framework regarding its shareholdings.

In addition to controls set out in the company's Articles of Association, NHS England appoints directors who sit on the Board and Committees of SCCL and holds quarterly accountability meetings to review performance against KPIs and financial targets, both of which are agreed by the NHS England board annually.

Counter fraud

NHS England has a dedicated counter fraud team which ensures that appropriate counter fraud arrangements are in place. This includes proactive activities to prevent and detect fraud, as well as reactive investigation of allegations of fraud related to our functions.

The Director of Financial Control has day-to-day operational responsibility for the function, and the Chief Financial Officer provides executive support and direction. We continued to work collaboratively with key partners in both proactive and reactive areas, including the Public Sector Fraud Authority, the DHSC, NHS Counter Fraud Authority, NHS Business Service Authority and law enforcement agencies.

NHS England public Inquiries

NHS England has a legal requirement to comply with Public Inquiries. In 2024/25 NHS England participated in or responded to the following:

- UK COVID-19 Public Inquiry[118]
- Thirlwall Public Inquiry[119] – circumstances around the crimes of Lucy Letby
- Fuller Independent Inquiry[120] – mortuaries/privacy and dignity of the deceased
- Lampard Public Inquiry[121] – investigating mental health inpatient deaths in Essex
- Angiolini Inquiry[122] – safety of women in public spaces after Sarah Everard's death
- Infected Blood Inquiry[123] – which published its final Report in May 2024.

Inquiry work in NHS England is led by a central team responsible for managing multiple inquiries. The Inquiry Team has developed a successful 'end to end' operating model for the lifespan of public inquiries; from their establishment to final reporting. This methodology includes locating and retrieving records from NHS England and legacy ALBs, managing the disclosure of evidence, as well as providing written and oral evidence.

As a Core Participant, NHS England reviews disclosed material, responds to evidence proposals for witnesses to provide insight in live hearings, makes oral submissions and informs the thinking of Inquiry Chairs. The team's rigorous process has enabled NHS England to provide 73 written statements, support 14 appearing witnesses and participate in over 200 days of public hearings.

The team sets and maintains high professional standards to help ensure that the NHS learns lessons and implements improvements to patient services, whilst making the best use of public funds. As part of our 'end to end' approach, we are building on work to support Baroness Thirlwall's assessment of historic recommendations, as well as learning from the Health Services Safety Investigations Body report on public inquiries "Recommendations but no action", in order to lead on the tracking and assuring implementation of inquiry recommendations in line with the Government's approach.

Some of the inquiries listed above will issue warning letters, reports and recommendations in 2025/26. The Inquiry team is therefore preparing for this, alongside supporting individuals through the organisation's transition, retaining legacy records and advising and supporting current and former staff. Preparatory work is also underway for newly announced inquiries into the events in Southport in Summer 2024 and the crimes committed by Valdo Calocane in Summer 2023.

[118] https://covid19.public-inquiry.uk/
[119] https://thirlwall.public-inquiry.uk/
[120] https://fuller.independent-inquiry.uk/
[121] https://lampardinquiry.org.uk/
[122] https://www.angiolini.independent-inquiry.uk/
[123] https://www.infectedbloodinquiry.org.uk/

Control issues

Managing third-party contracts

NHS England's commercial delivery teams manage 2,800+ active contracts (with an approximate value of £15.5 billion), that are critical to the delivery of services for the NHS. These are managed in line with NHS England's Contract Management Framework, which is based on Government Commercial Function methodology, which has been updated to reflect recent legislative and policy requirements. All Contract Management team members have either successfully completed the corresponding Government Commercial Function Accreditation or are actively working towards achieving accreditation. In line with the government's transparency agenda, NHS England comply with notice publication requirements including commercial pipeline publication of contracts above £2 million, and publication of contract award notices above £10k.

Overpayments to medical practitioners

Following the identification of overpayments to medical practitioners in 2021/22 and 2022/23, a new process has been implemented. Since April 2024, all payments to suspended medical practitioners have been centralised and are now processed by the national team.
The new process ensures that a standardised approach to applying the guidance is in place and the monthly assurance process to reconfirm eligibility allows for changes to circumstances to be actioned quickly to prevent overpayments. During 2024/25, one small overpayment of £277 occurred as a result of unique circumstances which do not undermine the new control environment overseeing these payments. An overpayment of £9k in 2024/25 was disclosed in the 2023/24 Annual Report and Accounts, as it was identified prior to the publication of that report.

Recoveries of previously identified overpayments continue to be pursued subject to legal advice.

Review of economy, efficiency and effective use of resources

Allocations

NHS England has responsibility for allocating the NHS funding agreed with the DHSC as part of our mandate. Please see the Chief Financial Officer's Report on page 43, for information on allocations.

ICB auditor referrals

5 ICBs were subject to 2024/25 referrals (2023/24: 14 referrals) to the Secretary of State by their auditor under Section 30 of the Local Audit and Accountability Act 2014, due to forecasting that expenditure would exceed income during the financial year.

Financial performance monitoring

The financial position across the commissioning system was reported monthly using the Integrated Single Financial Environment (ISFE) system and through provision of supporting information. These collections included key elements of provider reporting which facilitated the focus on overall system reporting. Alongside this, NHS providers continued to report their

monthly financial position to NHS England. This reporting has enabled a detailed monthly review by regional and national finance leadership teams and NHS England's Chief Financial Officer.

Individual ICB, system, direct commissioning and provider financial performance is monitored against KPIs including balance sheet indicators and performance against efficiency plans, in addition to the reported forecast and year-to-date position.

The financial position of commissioners is consolidated and reported in the overall NHS England accounts. NHS England is not the parent entity of NHS trusts and NHS foundation trusts; the financial position of providers is reported separately in the consolidated NHS provider accounts.

Cabinet Office efficiency controls

As part of the Government's control of expenditure, NHS England are subject to specified expenditure controls. These controls cover a range of expenditure categories and require proposed expenditure to be approved to secure best value for money and ensure efficiency is being maximised. For expenditure above certain thresholds in specified categories (including professional services and consultancy), onward approval is also sought from the DHSC and for some cases this also requires approval from the Minister, Cabinet Office, and/or HM Treasury

Ministerial Directions

The Secretary of State gave 11 directions to NHS England under section 254 of the Health and Social Care Act 2012 to establish and operate information systems i.e. systems for the collection or analysis of information relating to health or social care. In addition, 23 direction specifications, which connected with existing directions, were also issued. The Secretary of state issued the routine financial directions, making provision for NHS England's budgets and financial limits.

Head of Internal Audit opinion

Internal audit's opinion is based on a programme of work designed to address the specific assurance requirements of the NHS England Board and Accounting Officer. It is their opinion of the overall adequacy and effectiveness of the NHS England framework of governance, risk management and internal control as they operated during the year to 31 March 2025. Results of internal audit work, including remedial actions agreed with management, have been regularly reported to management and ARAC.

The opinion is given following the Prime Minister's announcement on 13 March that NHS England will be abolished, that a programme of work would bring NHS England back into the Department of Health and Social Care, and that significant organisational changes and uncertainty are to be expected. At the time the announcement was made, the majority of the internal audit work had been completed, and the opinion is expressed in the context of this.

The opinion of internal audit is that the design of the governance and risk management framework for the year were effective, except for the SFIs which had not been fully updated but

were being reset at the year-end following announcements in March 2025 on NHS England's integration into the DHSC. A paper to update the SFIs was approved by the NHS England Board in June 2025, with a full update planned for later in 2025/26.

The advice of internal audit is that it is fundamental that the reset of the governance and risk management frameworks be kept under review during 2025/26 to confirm they remain appropriate during transition.

Internal audit concluded that limited assurance could be provided over the effectiveness and efficiency of the internal control framework, with the exception of four areas where they were unable to provide assurance because either previous actions remained in progress, the areas were not ready to audit, or known historical issues had not been addressed. Actions have been agreed for each of these areas after the reporting period and are being progressed to address the recommendations.

The organisation has continued to be under significant operational pressure and was subject to further change including substantial changes to the executive (see page 55) and delegation of specialised commissioning functions to ICBs. Actions have been agreed throughout 2024/25 to address the issues identified by internal audit. However, implementing actions in a timely manner has been challenging in the context of the ongoing operational pressures, and management continue to focus on this.

Despite the challenging operating environment, internal audit noted that a number of mechanisms have been put in place during the year to confirm compliance with corporate policies and procedures, including travel and expenses monitoring and contingent labour. The agreed management actions from the 2023/24 internal audit of dental contract management, which was given a 'no assurance' rating, were addressed during 2024/25.

There remains significant reliance on third party providers of core services, such as payroll processing, and there remains a requirement to further embed the contract management framework to obtain assurance over the delivery of services.

Some of the weaknesses in internal controls for core processes were assessed as being fundamental to the system of controls. Management actions have been agreed to address these observations, not all of which were completed by year end given their nature, but where possible, interim solutions have been put in place.

Remuneration and staff report

Our people

Our NHS People Plan[124] ambitions and values drive our workforce strategy, which aims for more staff working flexibly in a compassionate and inclusive culture. Alongside our People Plan, our NHS People Promise[125] sets out our pledge to one another and describes how we want to improve the experience of working in the NHS for everyone.

Organisational change

The Government announced on 13 March 2025 that NHS England will be abolished as an arm's length body and integrated into a restructured DHSC, with the total headcount reduced by 50%. We have started conversations with colleagues in Government about the design of the new the DHSC and the timetable for this transition. We appointed Richard Barker in May 2025 as Senior Responsible Owner to lead the joint transformation programme. We continue to work closely with the DHSC to design and implement the new organisation that will bring together many of the existing functions of NHS England and the DHSC.

Our values

Contributions from across the organisation helped define our new values that would shape the culture of NHS England. Over 650 colleagues participated in workshops and gave written feedback. This collaborative effort helped develop and define our new values and set the tone for our new organisation. This saw the introduction of three new organisational values: collaboration, inclusion, and learning and improvement.

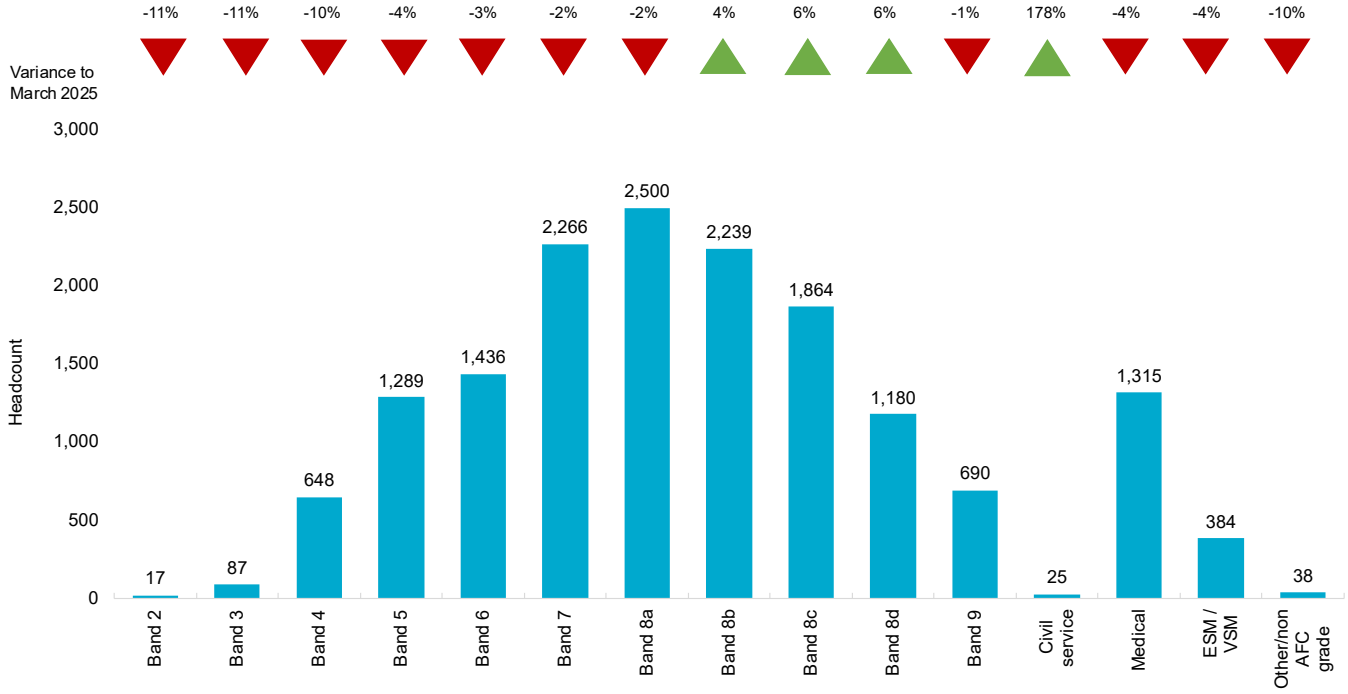
[124] https://www.england.nhs.uk/ournhspeople/
[125] https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/

Our workforce

Staff numbers

On 31 March 2025, NHS England directly employed 15,978 staff (14,492 WTE). Of these, 15,477 were permanently employed, and 501 were employed on payroll on fixed term contracts of employment.

Staff by grade



The chart shows the headcount by pay band on 31 March 2025. Detail on staff numbers and costs for NHS England and the consolidated group, including CSUs, are presented from page 94.

The headcount of permanent and fixed term staff in NHS England decreased by 1% since 31 March 2024.

Staff turnover

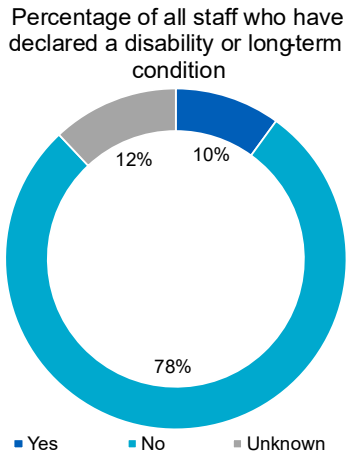
Turnover decreased in 2024/25 compared to 2023/24. Both the headcount and the number of people leaving the organisation decreased.

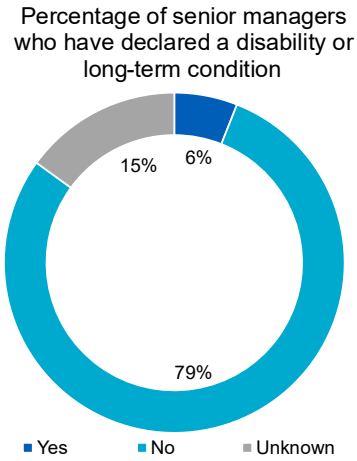
Staff turnover (%)

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
NHS England	14.0%	13.2%	4.88%	9.65%	11.01%	16.52%	7.09%
NHS TDA	14.9%	15.2%	4.65%	7.30%	8.10%	N/A	N/A
Monitor	19.4%	29.5%	4.13%	11.58%	2.21%	N/A	N/A
NHS Digital	-	-	-	11.79%	10.17%	N/A	N/A
Total	**14.7%**	**14.0%**	**4.85%**	**10.00%**	**10.90%**	**16.52%**	**7.09%**

Equality, diversity, and inclusion

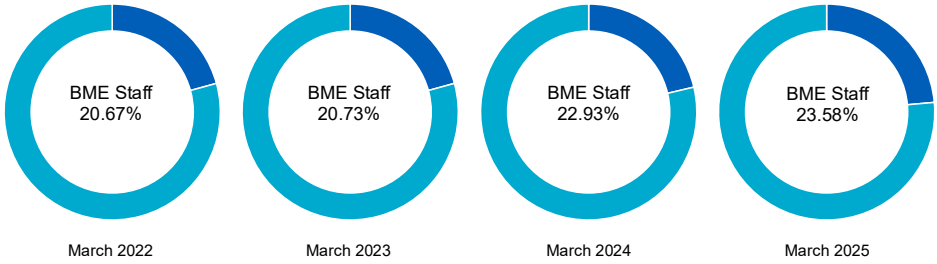
The charts below reflect the proportion of all staff and senior managers who have reported a disability or long-term conditions, in ESR.





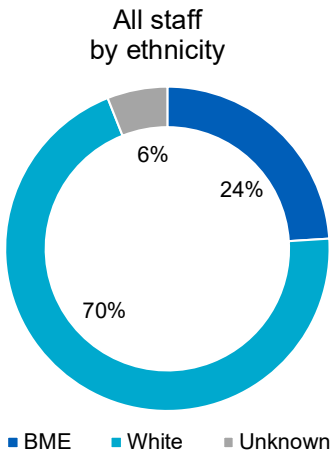
Ethnicity of all staff and senior managers

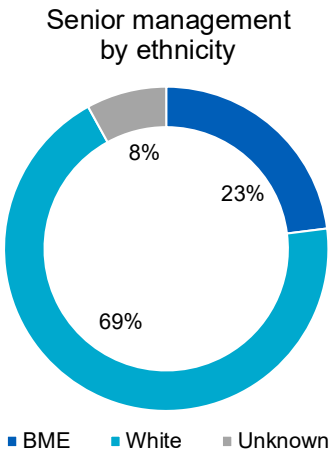
Figures below show the overall percentage of black or minority ethnic (BME) staff and the change over the last 3 years:



The proportion of people employed by NHS England who consider themselves to be from a BME heritage increased by 0.7 ppts between 31 March 2024 and 31 March 2025.

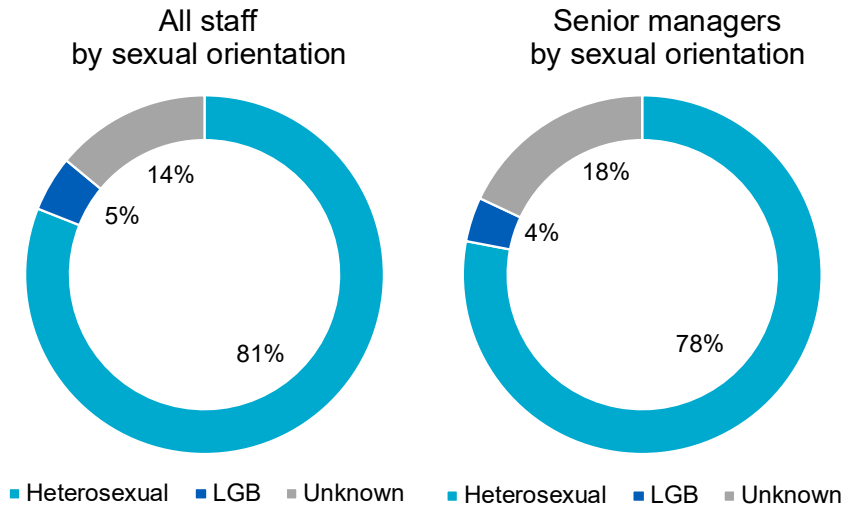
The graphs below show ethnicity for all staff and senior managers, as reported in ESR.
The proportion of senior managers who identify as BME has increased from 22.7% in 2023/24 to 23.1% in 2024/25.





Sexual orientation of staff and senior managers

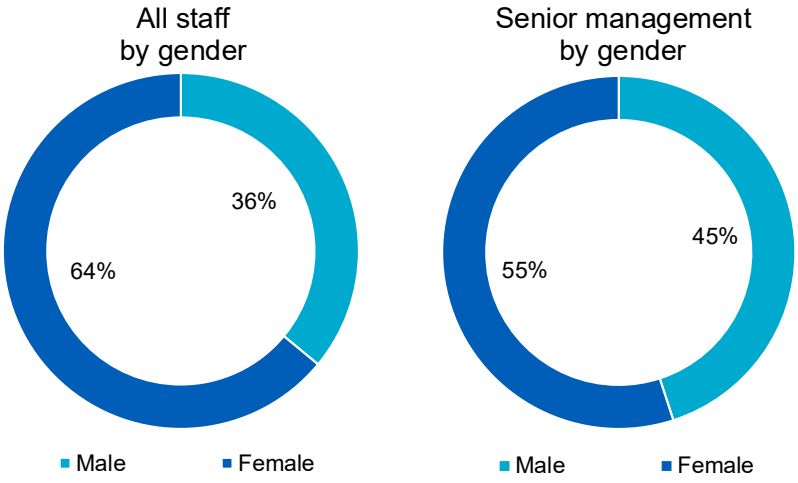
The percentage of staff who disclose their identity as lesbian, gay and bisexual (LGB) is 4.9% as of March 2025. The breakdown of sexual orientation declaration is detailed below, including an overview of senior managers who have declared as LGB in ESR (4.1%).



Gender of all staff and senior managers

The female gender profile of the total NHS England 'on payroll' workforce decreased by 0.7% between 31 March 2024 and 31 March 2025. There has been an increase in the number of female senior managers from 54.7% on 31 March 2024 to 55.4% on 31 March 2025.
The gender diversity of NHS England Board members is set out on page 54 and the graphs below highlight gender reporting in ESR:

All staff and senior managers by gender

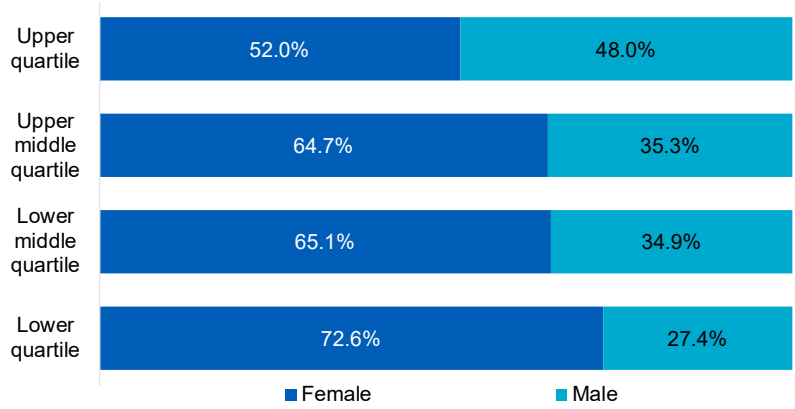


Gender pay gap 2024

We have produced a gender pay gap report as at 31 March 2024. The gender pay gap trend for NHS England is positive, with improvements made from the previous year. The mean gender pay gap was 11.41% in March 2024, representing a reduction in the gap of more than 5% over four years.

Year	Mean gender pay gap
2024	11.4%
2023	11.8%
2022	14.7%
2021	16.2%
2020	16.7%

Pay quartiles by gender in NHS England



In NHS England 52% of women are in the highest paid jobs compared to 48% men. In contrast, 73% of women are in the lowest paid jobs compared to 27% men.

The pay gap is a result of having a smaller proportion of men in lower pay bands. Although the mean salaries for women across pay bands 2 to 7 are higher, their mean earnings are considerably less than men across bands 8b and above. Similarly, we have the highest proportion of women in pay bands 5 to 8a compared to men who have a higher proportion in bands 8b and above.

Sickness absence

Sickness absence for the period 1 April 2024 to 31 March 2025 was as follows:

	WTE days available	WTE days lost to sickness absence	Sickness absence rate
NHS England 2024/25	5,217,850	158,887	3.05%
NHS England 2023/24	5,663,098	140,459	2.48%

Employment policies

We have a range of employment policies that reflect the culture of NHS England and support our ambition to be an Employer of Choice. Our priorities include:

- Continue to develop effective working relationships with our trade union colleagues on our Policy Subgroup.
- Develop a model to effectively engage with all areas of the business to ensure stakeholder feedback is considered when reviewing policies.
- Harmonise the three legacy policies on attendance management.
- Focus on the review of the policies on our policy schedule.
- Lead on the policy development for the new internal Sexual Misconduct policy, which was launched as part of the National Domestic Abuse and Sexual Violence programme in response to new legal responsibilities.
- Development of policy summaries for the most used HR policies, to support accessibility.
- Continue to work closely with the National Policy team to enable us to adapt and align our policies to the National People Policy Framework.

Partnership working

NHS England fully recognises the vital contribution of trade unions in representing the interests of colleagues and our organisation. We work closely in partnership with our recognised trade unions on important employment matters. Partnership work includes consulting on organisational change, as a legal requirement, as well as developing and refining our policies and discussing and negotiating on a wide range of issues affecting people and the organisation.

To facilitate partnership working, NHS England has a National Partnership Forum that meets every quarter. This forum provides strategic direction for other important sub-groups that focus on specific issues. Sub-groups include policy, organisational change, equality and diversity and the Local Negotiating Committee. In addition, we hold regional and corporate engagement forums to address any local issues, that can be escalated to the national partnership structure(s).

Trade union facility time disclosures

We fulfil our obligations under the Trade Union (Facility Time Publication Requirements) Regulations 2017 for 2024/25 by reporting the information to form part of the government's public sector trade union facility time data, which is published on the gov.uk website in August each year.[126]

Trade union representatives – the total number of employees who were trade union representatives during 2024/25

Number of employees who were relevant union officials during the relevant period	WTE employee number
88	85.14

Percentage of time spent on facility time (duties and activities):

Percentage of time	Number of employees
0%	56
1-50%	31
51-99%	0
100%	1

Percentage of pay bill spent on facility time:

Description	Figures
Provide the total cost of facility time	£193,550[127]
Provide the total pay bill	£1,288,700,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time – total pay bill) x 100	0.02%

Paid trade union activities:

Description	Figures
Hours spent on paid facility time	5469.5
Hours spent on paid trade union activities	1068
Percentage of total paid facility time hours spent on paid Trade Union activities	19.53%

Staff networks

We remain committed to building a fairer, more diverse organisation. Our 13 national Staff Networks play a vital role in this, providing safe spaces for colleagues to share lived experiences and helping shape an inclusive culture. We work with them as strategic partners, using their insights to drive meaningful change.

[126] https://www.gov.uk/guidance/report-trade-union-facility-time-data
[127] This figure is rounded up using Cabinet office's reporting criteria.

Talent management, Learning and Development

Data indicates an under representation of some protected characteristics at some grades. An inclusive recruitment handbook and a supporting training package have been designed and delivered to over 2,000 recruiting managers and other staff. A pilot Accelerated Development Programme has also been established to provide development placements of 12 months for colleagues from BME, disabled and LGB communities.

We introduced a mandatory four-module Line Manager Development programme designed to reset, refresh, and upskill our leaders. The programme, rolled out to 6,000 line managers, aims to drive culture transformation in line with our organisational values, with practical tools, models and techniques.

A new approach to one-to-one meetings and appraisals was launched to provide a simple, consistent performance management framework. It focuses on celebrating individual successes, identifying areas for improvement and supporting colleagues to perform at their best.

We have renewed our Learning and Development Managed Service Contract which provides one portal for colleagues to access a wide range of Learning and Development suppliers with opportunities ranging from technical, professional, leadership and management and coaching and skills development. The new contract maintains continuity of provision for NHS England and aims to increase value add by improving the quality and choice of provision.

Employee benefits and staff numbers (subject to audit)

Detail on staff numbers and costs for NHS England and the consolidated group, including CSUs, are presented in the following tables:

Average number of people employed

Parent 2024/25	Permanently employed number	CSU employed number	Other number	CSU other number	Total number
Total	14,120	5,946	939	48	**21,053**
Of the above:					
Number of WTE people engaged on capital projects	77	-	11	-	**88**

Parent 2023/24	Permanently employed number	CSU employed number	Other number	CSU other number	Total number
Total	14,716	6,492	1,912	113	**23,233**
Of the above:					
Number of WTE people engaged on capital projects	66	-	31	-	**97**

Consolidated group 2024/25	Permanently employed number	CSU employed number	Other number	CSU other number	Total number
Total	37,771	5,946	2,138	48	**45,903**
Of the above:					
Number of WTE people engaged on capital projects	77	-	11	-	**88**

Consolidated group 2023/24	Permanently employed number	CSU employed number	Other number	CSU other number	Total number
Total	38,512	6,492	3,720	113	**48,837**
Of the above:					
Number of WTE people engaged on capital projects	66	-	31	-	**97**

Employee benefits

Parent group 2024/25	Permanently employed £000	Permanent CSU employees £000	Other £000	CSU other £000	Total £000
Employee benefits					
Salaries and wages	965,059	290,506	83,628	4,282	**1,343,475**
Social security costs	111,503	31,886	2	-	**143,391**
Employer contributions to NHS Pension Scheme	205,176	62,203	3	-	**267,382**
Apprenticeship Levy	4,905	1,403	-	-	**6,308**
Termination benefits	2,057	6,056	-	-	**8,113**
Gross employee benefits expenditure	**1,288,700**	**392,054**	**83,633**	**4,282**	**1,768,669**
Less: Employee costs capitalised	(7,612)	-	(1,293)	-	**(8,905)**
Net employee benefits excluding capitalised costs	**1,281,088**	**392,054**	**82,340**	**4,282**	**1,759,764**
Less recoveries in respect of employee benefits	(459)	-	-	-	**(459)**
Total net employee benefits	**1,280,629**	**392,054**	**82,340**	**4,282**	**1,759,305**

Parent group 2023/24	Permanently employed £000	Permanent CSU employees £000	Other £000	CSU other £000	Total £000
Employee benefits					
Salaries and wages	964,168	295,713	147,043	9,981	**1,416,905**
Social security costs	116,970	33,039	7	-	**150,016**
Employer contributions to NHS Pension Scheme	177,549	55,080	9	-	**232,638**
Other pension costs	-	-	-	-	**-**
Apprenticeship Levy	4,811	1,510	-	-	**6,321**
Termination benefits	(6,492)	9,281	-	-	**2,789**
Gross employee benefits expenditure	**1,257,006**	**394,623**	**147,059**	**9,981**	**1,808,669**
Less: Employee costs capitalised	(6,028)	-	(5,244)	-	**(11,272)**
Net employee benefits excluding capitalised costs	**1,250,978**	**394,623**	**141,815**	**9,981**	**1,797,397**
Less recoveries in respect of employee benefits	120	-	-	-	**120**
Total net employee benefits	**1,251,098**	**394,623**	**141,815**	**9,981**	**1,797,517**

Consolidated group 2024/25	Permanently employed £000	Permanent CSU employees £000	Other £000	CSU other £000	Total £000
Employee benefits					
Salaries and wages	2,321,966	290,506	173,427	4,282	**2,790,181**
Social security costs	267,128	31,886	612	-	**299,626**
Employer contributions to NHS Pension Scheme	487,537	62,203	750	-	**550,490**
Other pension costs	6,516	-	-	-	**6,516**
Apprenticeship Levy	11,100	1,403	-	-	**12,503**
Termination benefits	4,053	6,056	-	-	**10,109**
Gross employee benefits expenditure	**3,098,300**	**392,054**	**174,789**	**4,282**	**3,669,425**
Less: Employee costs capitalised	(7,612)	-	(1,293)	-	**(8,905)**
Net employee benefits excluding capitalised costs	**3,090,688**	**392,054**	**173,496**	**4,282**	**3,660,520**
Less recoveries in respect of employee benefits	(4,026)	-	(2)	-	**(4,028)**
Total net employee benefits	**3,086,662**	**392,054**	**173,494**	**4,282**	**3,656,492**

Consolidated group 2023/24	Permanently employed £000	Permanent CSU employees £000	Other £000	CSU other £000	Total £000
Employee benefits					
Salaries and wages	2,247,931	295,713	276,697	9,982	**2,830,323**
Social security costs	264,634	33,039	766	-	**298,439**
Employer contributions to NHS Pension Scheme	409,773	55,079	812	-	**465,664**
Other pension costs	4,810	-	-	-	**4,810**
Apprenticeship Levy	10,819	1,511	-	-	**12,330**
Termination benefits	76,665	9,281	-	-	**85,946**
Gross employee benefits expenditure	**3,014,632**	**394,623**	**278,275**	**9,982**	**3,697,512**
Less: Employee costs capitalised	(6,028)	-	(5,244)	-	**(11,272)**
Net employee benefits excluding capitalised costs	**3,008,604**	**394,623**	**273,031**	**9,982**	**3,686,240**
Less recoveries in respect of employee benefits	(4,925)	-	-	-	**(4,925)**
Total net employee benefits	**3,003,679**	**394,623**	**273,031**	**9,982**	**3,681,315**

CSUs are part of NHS England and provide services to ICBs and other external bodies.

The employment contracts or secondment of almost all of these staff are held for NHS England on a “hosted basis” by the NHS Business Services Authority.

Exit packages, severance payments and off-payroll engagements

Expenditure on consultancy and contingent labour

Expenditure on consultancy is detailed in the Annual Accounts under Note 4: Operating expenses. NHS England and CSUs procured consultancy services worth £16.9 million during the financial year, a decrease of £260k since the previous year (2023/24: £17.1 million).

Across the group, there was a total spend of £48.4 million on consultancy services during the period, against £56.5 million the previous year.

Expenditure on contingent labour, including agency staff and secondees, is given in the employee benefits table on page 95, under the 'other' column.

Net expenditure for NHS England and CSUs in this area was £88 million in 2024/25, against £157 million in 2023/24. Across the group, there was a total spend of £179 million on contingent labour during the year, against £288.3 million the previous year.

Further detail on efficiency controls, and steps we have taken to improve procurement practices and compliance within NHS England during the year, can be found in our governance statement from page 67.

Contingent labour	2024/25 £000	2023/24 £000	(Increase) / Decrease £000
Parent including CSU other	87,915	157,040	69,125
Group other	179,071	288,257	109,186

Consultancy	2024/25 £000	2023/24 £000	(Increase) / Decrease £000
Parent consultancy	16,886	17,146	260
Group consultancy	48,363	56,457	8,094

Off-payroll engagements

NHS England is committed to employing a capable, talented, and diverse on-payroll workforce to support the delivery of its business. It is recognised that in some specific circumstances the use of off-payroll workers (OPWs), working alongside our on-payroll workforce, can be helpful. For some of our time-limited programmes, short-term contracts are appropriate. The following tables identify OPWs engaged by NHS England at March 2025. OPWs engaged by ICBs are reported in ICB annual reports and published on their websites.[128]

[128] https://www.england.nhs.uk/publication/integrated-care-boards-in-england/

Off-payroll engagements longer than 6 months

Off-payroll engagements on 31 March 2025, covering those earning more than £245[129] per day are as follows:

Off-payroll engagements longer than 6 months	NHS England (number)	CSUs (number)	Total (number)
Number of existing engagements as of 31 March 2025	1,071	31	1,102
Of which, the number that have existed:			
for less than 1 year at the time of reporting	403	28	431
for between 1 and 2 years at the time of reporting	356	3	359
for between 2 and 3 years at the time of reporting	299	-	299
for between 3 and 4 years at the time of reporting	2	-	2
for 4 or more years at the time of reporting	11	-	11

The reporting methodology has changed since the previous year to include individuals engaged via third party contracts in addition to agency workers.

The majority of the individuals reported above were engaged via third party contracts mainly undertaking software development and maintenance on the main digital platforms such as the NHS App.

All off-payroll engagements were subject to a risk-based assessment as to whether assurance was required that the individual was paying the right amount of tax and, where necessary, assurance has been sought.

New off-payroll engagements

New off-payroll engagements or those that reached 6 months in duration, between 1 April 2024 and 31 March 2025, for more than £245[130] per day are as follows:

New off-payroll engagements	NHS England (number)	CSUs (number)	Total (number)
Number of OPWs engaged during the year ended 31 March 2025	1,789	93	1,882
Of which:			
Number not subject to off payroll legislation[131]	-	-	-
Number subject to off-payroll legislation and determined as in-scope of IR35[131]	1,789	82	1,871
Number subject to off-payroll legislation and determined as out of scope of IR35[131]	-	11	11
Number of engagements reassessed for compliance or assurance purposes during the year	-	-	-
Of which:			
Number of engagements that saw a change to IR35 status following review	-	-	-

[129] The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.
[130] The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.
[131] A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Off-payroll board member/senior official engagement

Off-payroll engagements of Board members and/or senior officials with significant financial responsibility between 1 April 2024 and 31 March 2025 are shown in the table below:

Off-payroll board member/senior official engagement	NHS England (number)	CSUs (number)	Total (number)
Number of off-payroll engagements of Board members and/or senior officers with significant financial responsibility, during the financial year	-	-	-
Total number of individuals on-payroll and off-payroll who have been deemed 'Board members and/or senior officials with significant financial responsibility' during the financial year	393	29	422

Details of exit packages agreed over the year are detailed in the following tables.

All contractual severance payments were subject to full external oversight by the DHSC.

Exit packages agreed during the year (subject to audit)

Parent	2024/25			2023/24		
	Compulsory redundancies Number	Other agreed departures Number	Total Number	Compulsory redundancies Number	Other agreed departures Number	Total Number
Less than £10,000	17	2	19	6	-	6
£10,001 to £25,000	48	-	48	2	-	2
£25,001 to £50,000	34	3	37	8	1	9
£50,001 to £100,000	37	2	39	8	2	10
£100,001 to £150,000	19	1	20	3	2	5
£150,001 to £200,000	10	-	10	2	1	3
Total	**165**	**8**	**173**	**29**	**6**	**35**
Total cost (£000)	**8,683**	**349**	**9,032**	**1,654**	**610**	**2,264**

Parent	Departures where special payments have been made 2024/25		Departures where special payments have been made 2023/24	
	Number	£	Number	£
£25,001 to £50,000	1	38,988	-	-
Total	**1**	**38,988**	**-**	**-**

Consolidated group	2024/25			2023/24		
	Compulsory redundancies Number	Other agreed departures Number	Total Number	Compulsory redundancies Number	Other agreed departures Number	Total Number
Less than £10,000	146	43	189	56	55	111
£10,001 to £25,000	119	79	198	31	143	174
£25,001 to £50,000	99	69	168	31	178	209
£50,001 to £100,000	108	96	204	25	171	196
£100,001 to £150,000	49	40	89	14	72	86
£150,001 to £200,000	28	15	43	20	38	58
Total	**549**	**342**	**891**	**177**	**657**	**834**
Total cost (£000)	**24,566**	**18,413**	**42,979**	**8,644**	**36,618**	**45,262**

Consolidated group	Departures where special payments have been made 2024/25		Departures where special payments have been made 2023/24	
	Number	£	Number	£
£25,001 to £50,000	1	38,988	-	-
Total	**1**	**38,988**	**-**	**-**

Analysis of other agreed departures (subject to audit)

Parent	2024/25		2023/24	
	Other agreed departures Number	Other agreed departures £000	Other agreed departures Number	Other agreed departures £000
Voluntary redundancies including early retirement contractual costs	6	203	6	610
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Contractual payments in lieu of notice	1	107	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	1	39	-	-
Total	**8**	**349**	**6**	**610**

Consolidated group	2024/25		2023/24	
	Other agreed departures Number	Other agreed departures £000	Other agreed departures Number	Other agreed departures £000
Voluntary redundancies including early retirement contractual costs	259	16,445	414	28,169
MARS contractual costs	27	726	230	8,175
Contractual payments in lieu of notice	73	1,034	25	267
Exit payments following Employment Tribunals or court orders	4	169	1	8
Non-contractual payments requiring HMT approval	1	39	-	-
Total	**364**	**18,413**	**670**	**36,619**

As a single exit package can be made up of several components, each of which will be counted separately in this table, the total number of exit packages will not necessarily match the total number in the table above.

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of NHS England.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

Where NHS England and ICBs have agreed early retirements, the additional costs are met by NHS England or the ICB and not by the NHS Pension Scheme and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that report.

People and Remuneration Committee

Detail on the role and activity of the People and Remuneration Committee is given in our Directors' Report on page 52.

Percentage change in remuneration of highest paid director (subject to audit)

Percentage change in remuneration of the highest paid director	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	0%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	6.88%	0%

The average percentage increase in salary and allowances from 2023/24 to 2024/25 can be explained by NHS England undergoing a mass organisational change following the merge with NHS Digital on 01 February 2023 and Health Education England on 01 April 2023.
This organisational change came into effect on 01 April 2024 and resulted in a change to NHS England's organisational staff profile. In addition to organisational change an AFC pay award of 5% was implemented.

Pay ratio information (subject to audit)

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director/member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director/member in NHS England in the financial year 2024/25 was £265,000 to £270,000 (2023/24: £265,000-£270,000). The relationship to the remuneration of the organisation's workforce is disclosed in the table below.

2024/25	25th percentile	Median	75th percentile
Total remuneration (£)	44,806	56,698	79,616
Salary component of total remuneration (£)	44,806	56,454	78,814
Pay ratio information	5.97:1	4.72:1	3.36:1
2023/24	**25th percentile**	**Median**	**75th percentile**
Total remuneration (£)	37,350	51,558	72,245
Salary component of total remuneration (£)	37,350	50,952	70,417
Pay ratio information	7.16:1	5.19:1	3.70:1

The pay ratio information for the 2024/25 financial year is consistent with the pay, reward and progression policies for the employees taken as a whole, due to applying all nationally mandated pay awards where applicable and adhering to the relevant pay progression principles.

In 2024/25, no employees received remuneration in excess of the highest-paid director/ member (2023/24: none). Remuneration ranged from £7,883 to £270,000 (2023/24: £7,883 to £270,000).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value (CETV) of pensions.

Policy on remuneration of senior managers

The framework for the remuneration of executive directors is set by the DHSC through the Executive Senior Mangers (ESM) pay framework for Arm's Length Bodies (ALBs).

It is NHS England's policy to pay salaries that are appropriate to recruit senior managers with the necessary skills, capability and experience for the effective running of a more than £191 billion organisation, while recognising the importance of demonstrating pay restraint at a time of considerable pressure on NHS finances. Recommending appropriate remuneration for executive directors was undertaken by the People and Remuneration Committee and the Nominations Committee. Final decisions are made by the DHSC ALB Remuneration Committee and HM Treasury, where appropriate.

Performance-related pay

The PRP arrangements for national (executive) directors are set out in the ESM pay framework for ALBs. They follow guidance prescribed by the DHSC and are in line with HM Treasury requirements. As a local policy decision, NHS England does not currently allocate any funding for PRP non-consolidated bonus payments. In recognition of the current economic climate and the need to provide effective system leadership for the NHS, the decision was taken by the Executive HR Group and the People and Remuneration Committee not to allocate funds for PRP non-consolidated bonus payments for 2024/25.

Secondees are subject to the terms and conditions of their employing organisation.

Policy on senior managers' contracts

Contracts of employment for senior managers are open-ended and recurrent, unless otherwise specified. Notice periods follow the provisions of the ESM contract of employment, as applied by NHS England, of six months' contractual notice.

Termination payments can only be authorised where they are contractual and, subject to the value involved, may still require further approval from the DHSC Governance and Assurance Committee.

Any proposed non-contractual special severance payment requires formal approval from the DHSC and HM Treasury.

Payments for loss of office (subject to audit)

No payments were made to any senior manager to compensate for loss of office in 2024/25.

Payments to past directors (subject to audit)

No payments have been made to past directors and no compensation has been paid on early retirement. This is subject to audit.

Senior managers' service contracts

Name and title	Date of appointment	Notice period	Provisions for compensation for early termination	Other details
Amanda Pritchard Chief Executive Officer	1 August 2021	6 months		Left NHS England 31 March 2025
Dame Emily Lawson Chief Operating Officer (Interim)	1 November 2023	6 months		Left COO post 31 March 2025
Stephen Russell Chief Delivery Officer	3 April 2023	6 months		Left CDO post 31 March 2025
Jacqueline Rock Chief Commercial Officer	1 January 2022	6 months		Left NHS England 31 December 2024
Professor Sir Stephen Powis National Medical Director	1 March 2018	6 months		
Julian Kelly Chief Financial Officer	1 April 2019	6 months	Option to provide taxable pay in lieu of part or all of the notice period	Left NHS England 31 March 2025
Dame Ruth May Chief Nursing Officer	7 January 2019	6 months		Left CNO post 24 July 2024
Duncan Burton Chief Nursing Officer for England	25 July 2024	6 months		
Dr Vinod Diwakar National Director of Transformation (Interim)	18 September 2023	6 months		
Christopher Hopson Chief Strategy Officer	13 June 2022	6 months		
Navina Evans Chief Workforce Officer	1 July 2022	6 months		

Remuneration (salary, benefits in kind and pensions) 2024/25 (subject to audit)

Name and title	(a) Salary (bands of £5,000) £000	(b) Benefits in kind (taxable) to nearest £100 £s	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long-term performance pay and bonuses (bands of £5,000) £000	(e) Pension-related benefits (bands of £2,500)[132] £000	(f) Total (a to e) (bands of £5,000) £000
Amanda Pritchard[133] Chief Executive Officer	385-390	0	0	0	10-12.5	395-400
Dame Emily Lawson[134] Chief Operating Officer (Interim)	260-265	0	0	0	0	260-265
Stephen Russell[135] Chief Delivery Officer	205-210	1,000	0	0	0	205-210
Jacqueline Rock[136] Chief Commercial Officer	160-165	2,100	0	0	97.5-100	260-265
Professor Sir Stephen Powis National Medical Director	240-245	0	0	0	0	240-245
Julian Kelly[137] Chief Financial Officer	230-235	0	0	0	55-57.5	290-295
Dame Ruth May[138] Chief Nursing Officer	60-65	300	0	0	0	60-65
Duncan Burton[139] Chief Nursing Officer for England	135-140	0	0	0	105-107.5	240-245
Dr Vinod Diwakar National Director of Transformation (Interim)	215-220	0	0	0	0	215-220
Christopher Hopson Chief Strategy Officer	215-220	0	0	0	52.5-55	270-275
Navina Evans Chief Workforce Officer	205-210	0	0	0	0	205-210

[132] The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the potential benefit of being a member of the pension scheme.
[133] Amanda Pritchard left NHS England on 31 March 2025 and received a Pay in Lieu of Notice (PILON) payment of £105,000-£110,000 and a Lieu of Annual Leave payment of £5,000-£10,000. The remuneration figure noted in the above table reflects the total of these two payments, plus Amanda's 2024/25 remuneration of £265,000-£270,000. However, the PILON and Lieu of Annual Leave payments were paid to Amanda during the 2025/26 reporting period.
[134] Dame Emily Lawson left the Chief Operating Officer post on 31 March 2025.
[135] Stephen Russell left the Chief Delivery Officer post on 31 March 2025. Stephen Russell's benefit in kind relates to a Lease Car.
[136] Jacqueline Rock left NHS England on 31 December 2024. The full year equivalent salary is £215,000-£220,000. Jacqueline Rock's benefit in kind relates to a Lease Car.
[137] Julian Kelly left NHS England on 31 March 2025 and received a Lieu of Annual Leave payment of £15,000-£20,000. The remuneration figure noted in the above table reflects the total of this payment, plus Julian's 2024/25 remuneration of £215,000-£220,000. However, the Lieu of Annual Leave payment was paid to Julian during the 2025/26 reporting period.
[138] Dame Ruth May left the Chief Nursing Officer post on 24 July 2024. The full year equivalent salary is £190,000-£195,000. Dame Ruth May's benefit in kind relates to a Lease Car.
[139] Duncan Burton commenced in post on 25 July 2024. The full year equivalent salary is £195,000-£200,000.

Remuneration (salary, benefits in kind and pensions) 2023/24 (subject to audit)

Name and title	(a) Salary (bands of £5,000) £000	(b) Benefits in kind (taxable) to nearest £100 £s	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long-term performance pay and bonuses (bands of £5,000) £000	(e) Pension-related benefits (bands of £2,500)[140] £000	(f) Total (a to e) (bands of £5,000) £000
Amanda Pritchard Chief Executive Officer	265-270	0	0	0	0	265-270
Sir David Sloman[141] Chief Operating Officer	95-100	0	0	0	0	95-100
Sir James Mackey[142] Chief Operating Officer (Interim)	0	0	0	0	0	0
Dr Emily Lawson[143] Chief Operating Officer (Interim)	110-115	0	0	0	0	110-115
Mark Cubbon[144] Chief Delivery Officer	0-5	0	0	0	0	0-5
Stephen Russell[145] Chief Delivery Officer	205-210	1,000	0	0	0	205-210
Jacqueline Rock[146] Chief Commercial Officer	220-225	2,800	0	0	50-52.5	275-280
Professor Sir Stephen Powis National Medical Director	240-245	0	0	0	0	240-245
Julian Kelly Chief Financial Officer	215-220	0	0	0	52.5-55	270-275
Dame Ruth May[147] Chief Nursing Officer	180-185	1,600	0	0	0	180-185
Dr Tim Ferris[148] National Director of Transformation	90-95	0	0	0	0	90-95
Dr Vinod Diwakar[149] National Director of Transformation (Interim)	110-115	0	0	0	12.5-15	120-125
Christopher Hopson Chief Strategy Officer	215-220	0	0	0	50-52.5	265-270
Navina Evans Chief Workforce Officer	205-210	0	0	0	0	205-210

[140] The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the potential benefit of being a member of the pension scheme.

[141] Sir David Sloman's salary was recharged to NHS England from the Royal Free London NHS Foundation Trust where he was also formally employed and retained a post. Sir David Sloman left NHS England on 03 September 2023. The full year equivalent salary is £230,000-£235,000.

[142] Sir James Mackey covered this post on an interim basis from 04 September 2023 to 31 October 2023 on an NHS assignment. Sir James Mackey's salary costs were retained wholly by Northumbria NHS Foundation Trust where he was formally employed and retained a post.

[143] Dr Emily Lawson commenced in post on an interim basis on 01 November 2023. The full year equivalent salary is £250,000-£255,000.

144 Mark Cubbon's salary was recharged to NHS England from Portsmouth Hospitals NHS Trust where he was also formally employed and retained a post. Mark Cubbon left NHS England on 02 April 2023. The full year equivalent salary is £220,000-£225,000.

[145] Stephen Russell commenced in post on 03 April 2023. Stephen Russell's benefit in kind relates to a Lease Car.

146 Jacqueline Rock's benefit in kind relates to a Lease Car.

147 Dame Ruth May's benefit in kind relates to a Lease Car.

[148] For the period 01 April 2023 to 09 May 2023 80% of the salary costs for Dr Tim Ferris were recharged to NHS England from Mass General Brigham Inc. where is he was also formally employed and retained a post, with NHS England directly funding the remaining 20%. For the period 10 May 2023 to 17 September 2023 NHS England directly funded 100% of the salary costs. Dr Tim Ferris left this post on 17 September 2023. The full year equivalent salary is £190,000-£195,000. NHS England also paid Mass General Brigham Inc. a retirement contribution of $0,000-$5,000.

[149] Dr Vinod Diwakar commenced in post on an interim basis on 18 September 2023. The full year equivalent salary is £205,000-£210,000.

Pension benefits (subject to audit)

Name and title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age on 31 March 2025 (bands of £5,000) £000	Lump sum at pension age related to accrued pension on 31 March 2025 (bands of £5,000) £000	CETV on 31 March 2025[150] £000	Real Increase in CETV £000	CETV on 31 March 2025 £000	Employer's contribution to partnership pension £000
Amanda Pritchard Chief Executive Officer	0-2.5	0	90-95	220-225	1,747	11	1,907	0
Dame Emily Lawson[151] Chief Operating Officer (Interim)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Stephen Russell Chief Delivery Officer	0	0	65-70	165-170	1,320	0	1,395	0
Jacqueline Rock[152] Chief Commercial Officer	5-7.5	N/A	15-20	N/A	153	76	259	0
Professor Sir Stephen Powis[153] National Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Julian Kelly Chief Financial Officer	2.5-5	N/A	25-30	N/A	331	43	422	0
Dame Ruth May[154] Chief Nursing Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Duncan Burton[155] Chief Nursing Officer for England	5-7.5	15-17.5	60-65	155-160	1,069	93	1,300	0
Dr Vinod Diwakar National Director of Transformation (Interim)	0	0	90-95	245-250	2,151	0	2,270	0
Christopher Hopson Chief Strategy Officer	2.5-5	N/A	10-15	N/A	120	43	197	0
Dr Navina Evans[156] Chief Workforce Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

[150] As per previous submissions, the column CETV on 31 March 2025 is the uninflated value whereas the real increase in CETV is the employer-funded increase.
[151] Dame Emily Lawson chose not to be covered by the NHS Pension arrangements during the reporting period.
[152] Jacqueline Rock left NHS England on 31 December 2024, therefore the Pension Benefits disclosed are pro-rata for this period.
[153] Professor Sir Stephen Powis chose not to be covered by the NHS Pension arrangements during the reporting period.
[154] Dame Ruth May chose not to be covered by the NHS Pension arrangements during the reporting period.
[155] Duncan Burton commenced in post on 25 July 2024, therefore the Pension Benefits disclosed are pro-rata for this period.
[156] Dr Navina Evans chose not to be covered by the NHS Pension arrangements during the reporting period.

Cash equivalent transfer values (subject to audit)

A CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time.

The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred into the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Pensions liability

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years." An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

Policy on remuneration of non-executive directors

The remuneration of non-executive directors is set by the DHSC on appointment and is non-pensionable. All non-executive directors are paid the same amount, except the Chair and Chair of ARAC, to reflect the equal time commitment expected from each non-executive director. The Chair and Chair of ARAC are entitled to higher amounts to reflect the increased time commitment associated with their respective roles.

Some non-executive directors, including one of the Deputy Chairs, have opted to waive their contractual remuneration. Non-executive directors do not receive PRP or pensionable remuneration.

Non-executive director service contracts

Name and title	Date of appointment	Unexpired term at 31 March 2025	Notice period	Provisions for compensation for early termination	Other details
Richard Meddings Chair	25 March 2022	0 months	3 months	None	Left on 31 March 2025
Wol Kolade Non-Executive Director and Deputy Chair	25 March 2022	0 months	3 months	None	Waived entitlement to remuneration Left on 24 March 2025
Jeremy Townsend Non-Executive Director Chair of ARAC	1 October 2020	18 months	3 months	None	
Michael Coupe Non-Executive Director	1 January 2021	21 months	3 months	None	
Sir Andrew Morris Non-Executive Director and Deputy Chair	1 July 2022	6 months	3 months	None	Appointment term extended for 6 months
Sir David Behan Non-Executive Director	1 September 2022	0 months	3 months	None	Left on 31 August 2024
Baroness Mary Watkins Non-Executive Director	27 January 2023	10 months	3 months	None	
Professor Sir Simon Wessely Non-Executive Director	27 January 2023	10 months	3 months	None	
Sir Mark Walport Non-Executive Director	27 January 2023	10 months	3 months	None	
Mark Bailie Non-Executive Director	19 February 2024	22.5 months	3 months	None	
Jane Ellison Non-Executive Director	19 February 2024	22.5 months	3 months	None	
Sir Robert Lechler Non-Executive Director	19 February 2024	22.5 months	3 months	None	
Professor Dame Helen Stokes-Lampard Non-Executive Director	19 February 2024	0 months	3 months	None	Left on 14 October 2024

Non-executive director remuneration (including salary entitlements)

Salaries and allowances 2024/25 (subject to audit)

Name of non-executive director	(a) Salary (bands of £5,000) £000	(b) Benefits in kind (taxable) rounded to nearest £100 £s	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long-term performance pay and bonuses (bands of £5,000) £000	(e) Pension-related benefits to the nearest £1,000[157] £000	(f) Total (a to e) (bands of £5,000) £000
Richard Meddings[158]	60-65	0	0	0	N/A	**60-65**
Wol Kolade[159]	0	0	0	0	N/A	**0**
Jeremy Townsend	10-15	0	0	0	N/A	**10-15**
Michael Coupe	5-10	0	0	0	N/A	**5-10**
Sir Andrew Morris	5-10	0	0	0	N/A	**5-10**
Sir David Behan[160]	0-5	0	0	0	N/A	**0-5**
Baroness Mary Watkins	5-10	0	0	0	N/A	**5-10**
Professor Sir Simon Wessely	5-10	0	0	0	N/A	**5-10**
Sir Mark Walport	5-10	0	0	0	N/A	**5-10**
Mark Bailie[161]	5-10	0	0	0	N/A	**5-10**
Jane Ellison	5-10	0	0	0	N/A	**5-10**
Sir Robert Lechler	5-10	0	0	0	N/A	**5-10**
Professor Dame Helen Stokes-Lampard[162]	0-5	0	0	0	N/A	**0-5**

[157] Non-executive directors do not receive pensionable remuneration and therefore have no pension-related benefits
[158] Richard Meddings donated 50% of his non-executive director remuneration to charity via NHS England's Give As You Earn scheme during the reporting period.
[159] Wol Kolade waived his entitlement to non-executive director remuneration. Wol Kolade left NHS England on 24 March 2025.
[160] Sir David Behan left NHS England on 31 August 2024. The full-year equivalent salary is £5,000-£10,000.
[161] Mark Bailie donated 100% of his non-executive director remuneration to charity via NHS England's Give As You Earn scheme during the reporting period.
[162] Professor Dame Helen Stokes-Lampard left NHS England on 14 October 2024. The full-year equivalent salary is £5,000-£10,000.

Salaries and allowances 2023/24 (subject to audit)

Name of non-executive director	(a) Salary (bands of £5,000) £000	(b) Benefits in kind (taxable) rounded to nearest £100 £s	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long-term performance pay and bonuses (bands of £5,000) £000	(e) Pension-related benefits to the nearest £1,000[163] £000	(f) Total (a to e) (bands of £5,000) £000
Richard Meddings[164]	60-65	0	0	0	N/A	**60-65**
Wol Kolade[165]	0	0	0	0	N/A	**0**
Jeremy Townsend	10-15	0	0	0	N/A	**10-15**
Laura Wade-Gery[166]	0-5	0	0	0	N/A	**0-5**
Rakesh Kapoor[167]	5-10	0	0	0	N/A	**5-10**
Susan Kilsby[168]	5-10	0	0	0	N/A	**5-10**
Michael Coupe	5-10	0	0	0	N/A	**5-10**
Professor Sir Munir Pirmohamed[169]	5-10	0	0	0	N/A	**5-10**
Sir Andrew Morris	5-10	0	0	0	N/A	**5-10**
Sir David Behan	5-10	0	0	0	N/A	**5-10**
Baroness Mary Watkins	5-10	0	0	0	N/A	**5-10**
Professor Sir Simon Wessely	5-10	0	0	0	N/A	**5-10**
Sir Mark Walport	5-10	0	0	0	N/A	**5-10**
Mark Bailie[170]	0-5	0	0	0	N/A	**0-5**
Jane Ellison[171]	0-5	0	0	0	N/A	**0-5**
Sir Robert Lechler[172]	0-5	0	0	0	N/A	**0-5**
Professor Dame Helen Stokes-Lampard[173]	0-5	0	0	0	N/A	**0-5**

[163] Non-executive directors do not receive pensionable remuneration and therefore have no pension-related benefits
[164] Richard Meddings donated 100% of his non-executive director remuneration to charity via NHS England's Give As You Earn scheme for the period 01 April 2023 to 31 October 2023, and 50% of his non-executive director remuneration from 01 November 2023.
[165] Wol Kolade waived his entitlement to non-executive director remuneration.
[166] Laura Wade-Gery left NHS England on 30 June 2023. The full-year equivalent salary is £5,000-£10,000.
[167] Rakesh Kapoor left NHS England on 31 December 2023. The full-year equivalent salary is £5,000-£10,000.
[168] Susan Kilsby left NHS England on 31 December 2023. The full-year equivalent salary is £5,000-£10,000.
[169] Professor Sir Munir Pirmohamed left NHS England on 31 December 2023. The full-year equivalent salary is £5,000-£10,000.
[170] Mark Bailie joined NHS England on 19 February 2024. The full-year equivalent salary is £5,000-£10,000. Mark Bailie donated 100% of his non-executive director remuneration to charity via NHS England's Give As You Earn scheme.
[171] Jane Ellison joined NHS England on 19 February 2024. The full-year equivalent salary is £5,000-£10,000.
[172] Sir Robert Lechler joined NHS England on 19 February 2024. The full-year equivalent salary is £5,000-£10,000.
[173] Professor Dame Helen Stokes-Lampard joined NHS England on 19 February 2024. The full-year equivalent salary is £5,000-£10,000.

Parliamentary accountability and audit report

All elements of this report are subject to audit.

Remote contingent liabilities

There were no remote contingent liabilities.

Notation of gifts over £300,000

NHS England made no political or charitable donations of gifts during 2024/25.

Regularity of expenditure: Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise and are therefore subject to special control procedures compared to the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Details of any losses and special payments relating to ICBs can be found within individual ICBs annual reports which are published on ICB websites. A list of ICBs along with links to their websites, can be found on the NHS England website.

Losses

The total number of NHS England losses cases, and their total value, was as follows:

	Parent				Consolidated group			
	Total number of cases 2024/25 Number	Total value of cases 2024/25 £000	Total number of cases 2023/24 Number	Total value of cases 2023/24 £000	Total number of cases 2024/25 Number	Total value of cases 2024/25 £000	Total number of cases 2023/24 Number	Total value of cases 2023/24 £000
Administrative write-offs	150	1,886	2	47	423	2,597	382	3,994
Fruitless payments	260	19,578	523	371	269	19,834	530	373
Stores losses	149	90	146,845	1,208	108,500	2,003	424,697	3,172
Bookkeeping losses	-	-	-	-	14	24	16	25
Constructive loss	-	-	-	-	1	1	-	-
Cash losses[174]	1,028	897	1	33	1,033	994	4	39
Claims abandoned	-	-	-	-	23	31	5	8
Total	**1,587**	**22,451**	**147,371**	**1,659**	**110,263**	**25,484**	**425,634**	**7,611**

2024/25 Disclosure: Administrative write off

£1 million - This relates to irrecoverable dental debts that were owed due to underperformance on the dental contracts.

£0.5 million - This write off relates to 25 GP irrecoverable aged debts due to being beyond the 6-year recovery period or dissolution of companies following liquidation.

[174] Cash losses in 2023/24 includes 9k relating to 2024/25 disclosed at the earliest opportunity, as per Managing Public Money guidance.

2024/25 Disclosure: Fruitless payments

£17 million - This payment is where continuing health care should have been awarded to individuals and when the payments were made including redress values, the tax liability was not deducted by CCG's and paid over to HMRC which is now due following various court proceedings.

£2.2 million - This relates to payroll worker tax compliance within the former Health Education England which has now transferred to NHS England upon the Health Education England and NHS England merger.

2024/25 Disclosure: Store losses

£2 million – Of this £1.9 million relates to various stock items that cannot be utilised in healthcare facilities as the stock has reached the manufacturers expiry date and therefore requires writing off.

2024/25 Disclosure: Cash losses

£0.9 million - These debts relate to irrecoverable bursaries that have been paid to eligible medical or dental students to cover costs incurred by students that were due to be paid back from scenarios such as the student leaving the course early.

2023/24 Disclosure: Store losses

£1.2 million - there is one instance comprising of multiple individual items for £1.1 million that relates to various stock items that cannot be utilised in healthcare facilities, as the stock has reached the manufacturer’s expiry date and therefore requires writing off.

Special payments

The total number of NHS England special payments cases, and their total value, was as follows:

	Parent				Consolidated group			
	Total number of cases 2024/25 Number	Total value of cases 2024/25 £000	Total number of cases 2023/24 Number	Total value of cases 2023/24 £000	Total number of cases 2024/25 Number	Total value of cases 2024/25 £000	Total number of cases 2023/24 Number	Total value of cases 2023/24 £000
Compensation payments	8	56	3	65	13	86	16	227
Compensation payments Treasury Approved	20	34	-	-	20	34	-	-
Extra Contractual Payments	-	-	1	51	3	133	3	52
Extra Contractual Payments Treasury Approved	1	4,058	-	-	1	4,058	1	8
Ex Gratia Payments	1	-	1	703	11	142	8	916
Ex Gratia Payments Treasury Approved	-	-	146	40	1	-	146	40
Special Severance Payments (requires Treasury approval)	1	39	-	-	1	39	-	-
Total	**31**	**4,187**	**151**	**859**	**50**	**4,492**	**174**	**1,243**

2024/25 Extra Contractual Payments

£4,058k - This is a claim for damages for breach of the General Ophthalmic Services contract brought by a supplier against NHS England.

2024/25 Special Severance Payments

There was 1 special severance payment that did not have HMT approval as follows:

NHS South, Central and West CSU

During 2024/25, the CSU has paid one special severance payment in the parent account for £38,988. It relates to a settlement agreement payment made to the individual. The payment was not approved by NHS England or HMT and is therefore irregular.

The payment noted above is also included in the Exit Package disclosures from page 100.

2023/24 Ex Gratia Payments

£703k - This case relates to the IR35 employment status assessments for all relevant OPWs engagements relating to the financial periods 2017 to 2019. 159 engagements of OPWs were deemed to have been subject to IR35 regulations and the payment due reflects the outcome of the assessment carried out. This payment relates to the negotiated settlement of the sum including interest due to HMRC in relation to those OPWs who based on a more recent understanding of HMRC interpretation of the rules and indicators, may have been incorrectly deemed out-of-scope.

Cost allocation and setting of charges

NHS England certifies that it has complied with the HM Treasury guidance on cost allocation and the setting of charges. The following table provides details of income generation activities whose full cost exceeded £1 million or was otherwise material:

2024/25		Parent			Consolidated group		
	Note	Income £000	Full cost £000	Surplus/ (deficit) £000	Income £000	Full cost £000	Surplus/ (deficit) £000
Dental	2 & 4	-	(92,751)	(92,751)	796,508	(3,718,746)	(2,922,238)
Prescription	2 & 4	-	(146,907)	(146,907)	730,413	(12,790,072)	(12,059,659)
Total fees and charges		**-**	**(239,658)**	**(239,658)**	**1,526,921**	**(16,508,818)**	**(14,981,897)**

2023/24		Parent			Consolidated group		
	Note	Income £000	Full cost £000	Surplus/ (deficit) £000	Income £000	Full cost £000	Surplus/ (deficit) £000
Dental	2 & 4	9,398	89,039	98,437	777,479	(3,108,156)	(2,330,677)
Prescription	2 & 4	(596)	(152,196)	(152,792)	693,188	(12,491,810)	(11,798,622)
Total fees and charges		**8,802**	**(63,157)**	**(54,355)**	**1,470,667**	**(15,599,966)**	**(14,129,299)**

The fees and charges information in this note is provided in accordance with section 6.7.1 of the Government FReM. It is provided for fees and charges purposes and not for IFRS 8 purposes. The financial objective of prescription and dental charges is to collect charges only from those patients that are eligible to pay.

Prescription charges[175] are a contribution to the cost of pharmaceutical services including the supply of drugs. In 2024/25, the NHS prescription charge for each medicine or appliance

[175] https://www.legislation.gov.uk/uksi/2024/456/contents/made

dispensed was £9.90. However, around 95% of prescription items[176] are dispensed without charge each year where patients are exempt from charges or hold a pre-payment certificate. In 2024/25 pre-payment certificates were charged at £32.05 for three months or £114.50 for a year. A number of other charges were payable for wigs and fabric supports.

Those who are not eligible for exemption are required to pay NHS dental charges[177] which fall into three bands depending on the level and complexity of care provided. From 1st April 2024, the charge for Band 1 treatments was £26.80, for Band 2 was £73.50 and for Band 3 was £319.10. Prior to this uplift the charge for Band 1 treatments was £25.80, for Band 2 was £70.70 and for Band 3 was £306.80.

[176] https://www.nhsbsa.nhs.uk/statistical-collections/prescription-cost-analysis-england/prescription-cost-analysis-england-202324, "Additional Tables", "Table 4A"
[177] https://www.legislation.gov.uk/uksi/2024/271/regulation/4/made

The certificate of the Comptroller and Auditor General to the Houses of Parliament

Opinion on financial statements

I certify that I have audited the financial statements of NHS England and its group for the year ended 31 March 2025 under the National Health Service Act 2006 and the Health and Social Care Act 2012.

The financial statements comprise NHS England and its group's

- Statement of Financial Position as at 31 March 2025;
- Statement of Comprehensive Net Expenditure, Statement of Cash Flows and Statement of Changes in Taxpayers' Equity for the year then ended; and
- the related notes including the significant accounting policies.

The financial reporting framework that has been applied in the preparation of the group financial statements is applicable law and UK adopted International Accounting Standards.

In my opinion, the financial statements:

- give a true and fair view of the state of NHS England and its group's affairs as at 31 March 2025 and their total net expenditure for the year then ended; and
- have been properly prepared in accordance with the National Health Service Act 2006 and the Health and Social Care Act 2012 and Secretary of State directions issued thereunder.

Opinion on regularity

In my opinion, in all material respects, the income and expenditure recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis for opinions

I conducted my audit in accordance with International Standards on Auditing (UK) (ISAs UK), applicable law and Practice Note 10 *Audit of Financial Statements and Regularity of Public Sector Bodies in the United Kingdom (2024)*. My responsibilities under those standards are further described in the *Auditor's responsibilities for the audit of the financial statements* section of my certificate.

Those standards require me and my staff to comply with the Financial Reporting Council's *Revised Ethical Standard 2019.* I am independent of NHS England and its group in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK. My staff and I have fulfilled our other ethical responsibilities in accordance with these requirements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that NHS England and its group's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on NHS England and its group's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for NHS England and its group is adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which requires entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue into the future.

Other Information

The other information comprises information included in the Annual Report but does not include the financial statements and my auditor's certificate thereon. The Board and Accounting Officer are responsible for the other information.

My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my certificate, I do not express any form of assurance conclusion thereon.

My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit, or otherwise appears to be materially misstated.

If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters

In my opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with Secretary of State directions issued under the National Health Service Act 2006 and the Health and Social Care Act 2012.

In my opinion, based on the work undertaken in the course of the audit:

- the parts of the Accountability Report subject to audit have been properly prepared in accordance with Secretary of State directions made under the National Health Service Act 2006 and the Health and Social Care Act 2012.
- the information given in the Performance and Accountability Reports for the financial year for which the financial statements are prepared is consistent with the financial statements and is in accordance with the applicable legal requirements.

Matters on which I report by exception

In the light of the knowledge and understanding of NHS England and its group's and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance and Accountability Reports.

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept by NHS England and its group or returns adequate for my audit have not been received from branches not visited by my staff; or
- I have not received all of the information and explanations I require for my audit; or
- the financial statements and the parts of the Accountability Report subject to audit are not in agreement with the accounting records and returns; or
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual have not been made or parts of the Remuneration and Staff Report to be audited is not in agreement with the accounting records and returns; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Responsibilities of the Board and Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the board and Accounting Officer are responsible for:

- maintaining proper accounting records;
- providing the C&AG with access to all information of which management is aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
- providing the C&AG with additional information and explanations needed for his audit;
- providing the C&AG with unrestricted access to persons within NHS England and its group from whom the auditor determines it necessary to obtain audit evidence;
- ensuring such internal controls are in place as deemed necessary to enable the preparation of financial statement to be free from material misstatement, whether due to fraud or error;
- preparing financial statements which give a true and fair view in accordance with Secretary of State directions made under the National Health Service Act 2006 and the Health and Social Care Act 2012;

- preparing the annual report, which includes the Remuneration and Staff Report, in accordance with Secretary of State directions made under the National Health Service Act 2006 and the Health and Social Care Act 2012; and
- assessing NHS England and its Group's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer anticipates that the services provided by NHS England and its group will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service Act 2006 and the Health and Social Care Act 2012.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations including fraud

I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulations, including fraud. The extent to which my procedures are capable of detecting non-compliance with laws and regulations, including fraud is detailed below.

Identifying and assessing potential risks related to non-compliance with laws and regulations, including fraud

In identifying and assessing risks of material misstatement in respect of non-compliance with laws and regulations, including fraud, I:

- considered the nature of the sector, control environment and operational performance including the design of NHS England and its group's accounting policies, key performance indicators and performance incentives.
- inquired of management, NHS England's head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to NHS England and its group's policies and procedures on:
    - identifying, evaluating and complying with laws and regulations;
    - detecting and responding to the risks of fraud; and
    - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including NHS England and its group's controls relating to NHS England's compliance with the National Health Service Act 2006, Health and Social Care Act 2012, Health and Care Act 2022 and Managing Public Money.

- inquired of management, NHS England's head of internal audit and those charged with governance whether:
  - they were aware of any instances of non-compliance with laws and regulations;
  - they had knowledge of any actual, suspected, or alleged fraud;
- discussed with the engagement team regarding how and where fraud might occur in the financial statements and any potential indicators of fraud.

As a result of these procedures, I considered the opportunities and incentives that may exist within NHS England and its group for fraud and identified the greatest potential for fraud in the following areas: revenue recognition, posting of unusual journals, complex transactions, bias in management estimates. In common with all audits under ISAs (UK), I am required to perform specific procedures to respond to the risk of management override.

I obtained an understanding of NHS England and its group's framework of authority and other legal and regulatory frameworks in which NHS England and its group operates. I focused on those laws and regulations that had a direct effect on material amounts and disclosures in the financial statements or that had a fundamental effect on the operations of NHS England and its group. The key laws and regulations I considered in this context included the National Health Service Act 2006, Health and Social Care Act 2012, Health and Care Act 2022, Managing Public Money, employment law, tax legislation, relevant legislation relating to fees charged by the NHS England, and regulations relating to suspension payments to suspended medical practitioners.

Audit response to identified risk

To respond to the identified risks resulting from the above procedures:

- I reviewed the financial statement disclosures and testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described above as having direct effect on the financial statements;
- I enquired of management and the Audit and Risk Assurance Committee concerning actual and potential litigation and claims;
- I reviewed minutes of meetings of those charged with governance and the Board and internal audit reports; and
- I addressed the risk of fraud through management override of controls by testing the appropriateness of journal entries and other adjustments; assessing whether the judgements on estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business.

I communicated relevant identified laws and regulations and potential risks of fraud to all engagement team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

A further description of my responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities.
This description forms part of my certificate.

Other auditor's responsibilities

I am required to obtain sufficient and appropriate audit evidence to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control I identify during my audit.

Report

I have no observations to make on these financial statements.

Gareth Davies 28 October 2025

Comptroller and Auditor General
National Audit Office, 157-197 Buckingham Palace Road, Victoria, London SW1W 9SP

Annual Accounts

Statement of comprehensive net expenditure for the year ended 31 March 2025

	Note	Parent		Consolidated group	
		2024/25 £000	2023/24 £000	2024/25 £000	2023/24 £000
Income from sale of goods and services	2	(607,736)	(546,415)	(6,319,642)	(5,754,594)
Other operating income	2	(3,382)	(5,759)	(92,184)	(124,829)
Total operating income		**(611,118)**	**(552,174)**	**(6,411,826)**	**(5,879,423)**
Staff costs	3	1,759,764	1,797,397	3,660,520	3,686,240
Purchase of goods and services	4	189,149,954	172,891,983	189,239,310	172,657,793
Depreciation and impairment charges	4	286,658	301,876	329,136	349,067
Provision expense	4	5,097	(109,547)	38,531	(125,442)
Other Operating Expenditure	4	232,263	165,803	3,827,392	3,411,034
Total operating expenditure		**191,433,736**	**175,047,512**	**197,094,889**	**179,978,692**
Net operating expenditure		**190,822,618**	**174,495,338**	**190,683,063**	**174,099,269**
Finance income		(12)	-	(33)	(19)
Finance expense	13	14,623	16,132	21,620	22,302
Net expenditure for the year		**190,837,229**	**174,511,470**	**190,704,650**	**174,121,552**
Other (gains)/losses		1,323	2,233	1,890	596
Net (gain)/loss on Transfer by Absorption	12	1,485	98,515	1,040	98,515
Total net expenditure for the year		**190,840,037**	**174,612,218**	**190,707,580**	**174,220,663**
Other comprehensive net expenditure					
Items which will not be reclassified to net operating costs					
Net (gain)/loss on revaluation of Financial Assets[178]		(64)	1,669	-	-
Total Other Comprehensive Net Expenditure		**(64)**	**1,669**	**-**	**-**
Comprehensive net expenditure for the year		**190,839,973**	**174,613,887**	**190,707,580**	**174,220,663**

On 1 April 2023 Health Education England became part of the NHS England parent account. As a result, the assets, liabilities and ongoing operational income and expenditure relating to the ex-Health Education England functions form part of the NHS England parent from that date.

The notes on pages 131 to 174 form part of this statement.

[178] The change in revaluation of financial assets represents the change on equity instruments measured at fair value through OCI in respect of NHS England investment in SCCL.

Statement of financial position as at 31 March 2025

		Parent		Consolidated group	
		31 March 2025	31 March 2024	31 March 2025	31 March 2024
Non-current assets	**Note**	**£000**	**£000**	**£000**	**£000**
Property, plant and equipment	5	310,282	350,005	355,871	418,922
Right of use assets	6	112,379	116,778	284,087	300,777
Intangible assets	7	537,979	420,188	583,482	435,264
Trade and other receivables	9	11,058	-	11,058	12
Other financial assets	9	139,857	139,793	1,106	1,106
Total non-current assets		**1,111,555**	**1,026,764**	**1,235,604**	**1,156,081**
Current assets					
Inventories	8	850	1,170	173,360	159,926
Trade and other receivables	9	800,042	770,826	2,524,540	2,488,945
Cash and cash equivalents	10	425,586	286,416	551,215	437,098
Total current assets		**1,226,478**	**1,058,412**	**3,249,115**	**3,085,969**
Total assets		**2,338,033**	**2,085,176**	**4,484,719**	**4,242,050**
Current liabilities					
Trade and other payables	11	(2,334,594)	(2,656,093)	(10,839,901)	(11,237,538)
Right of use asset lease liabilities	6	(22,257)	(20,250)	(46,672)	(49,485)
Other financial liabilities	11	-	-	(18,269)	(29,812)
Provisions	14	(70,738)	(61,983)	(195,373)	(221,722)
Total current liabilities		**(2,427,589)**	**(2,738,326)**	**(11,100,215)**	**(11,538,557)**
Total assets less current liabilities		**(89,556)**	**(653,150)**	**(6,615,496)**	**(7,296,507)**
Non-current liabilities					
Trade and other payables	11	-	(16)	(7,985)	(7,761)
Right of use asset lease liabilities	6	(98,114)	(104,160)	(246,768)	(259,127)
Other financial liabilities	11	-	-	(100,000)	(106,000)
Provisions	14	(274,846)	(307,591)	(312,914)	(348,562)
Total non-current liabilities		**(372,960)**	**(411,767)**	**(667,667)**	**(721,450)**
Total assets less total liabilities		**(462,516)**	**(1,064,917)**	**(7,283,163)**	**(8,017,957)**
Financed by taxpayers' equity and other reserves					
General fund		(445,434)	(1,047,932)	(7,285,224)	(8,020,187)
Revaluation reserve		2,061	2,222	2,061	2,230
Other reserves		(19,143)	(19,207)	-	-
Total taxpayers' equity		**(462,516)**	**(1,064,917)**	**(7,283,163)**	**(8,017,957)**

The notes on pages 131 to 174 form part of this statement.

The financial statements on pages 125 to 129 were approved by the Board and signed on its behalf by:

Sir James Mackey, Accounting Officer, 21 October 2025

Statement of changes in taxpayers' equity for the year ended 31 March 2025

Parent 2024/25	Note	General fund £000	Revaluation reserve £000	Other reserves £000	Total taxpayers' equity £000
Balance at 01 April 2024		**(1,047,932)**	**2,222**	**(19,207)**	**(1,064,917)**
Changes in Total Taxpayers' Equity for 2024/25					
Total Net Expenditure for the year		(190,840,037)			(190,840,037)
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)		-	-	64	64
Transfers between reserves		161	(161)	-	-
Comprehensive net expenditure for the year		**(190,839,876)**	**(161)**	**64**	**(190,839,973)**
Grant in Aid		191,442,374	-	-	191,442,374
Balance at 31 March 2025		**(445,434)**	**2,061**	**(19,143)**	**(462,516)**

Parent 2023/24	Note	General fund £000	Revaluation reserve £000	Other reserves £000	Total taxpayers' equity £000
Balance at 01 April 2023		**(3,152,183)**	**2,230**	**(17,538)**	**(3,167,491)**
Changes in Total Taxpayers' Equity for 2023/24					
Total Net Expenditure for the year		(174,612,218)			(174,612,218)
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)		-	-	(1,669)	(1,669)
Transfers between reserves		8	(8)	-	-
Comprehensive net expenditure for the year		**(174,612,210)**	**(8)**	**(1,669)**	**(174,613,887)**
Grant in Aid		176,716,461	-	-	176,716,461
Balance at 31 March 2024		**(1,047,932)**	**2,222**	**(19,207)**	**(1,064,917)**

Consolidated group 2024/25	Note	General fund £000	Revaluation reserve £000	Other reserves £000	Total taxpayers' equity £000
Balance at 01 April 2024		**(8,020,187)**	**2,230**	**-**	**(8,017,957)**
Changes in Total Taxpayers' Equity for 2024/25					
Total Net Expenditure for the year		(190,707,580)			(190,707,580)
Transfers between reserves		169	(169)	-	-
Comprehensive net expenditure for the year		**(190,707,411)**	**(169)**	**-**	**(190,707,580)**
Grant in Aid		191,442,374	-	-	191,442,374
Balance at 31 March 2025		**(7,285,224)**	**2,061**	**-**	**(7,283,163)**

Consolidated group 2023/24	Note	General fund £000	Revaluation reserve £000	Other reserves £000	Total taxpayers' equity £000
Balance at 01 April 2023		**(10,515,993)**	**2,238**	**-**	**(10,513,755)**
Changes in Total Taxpayers' Equity for 2023/24					
Total Net Expenditure for the year		(174,220,663)	-	-	(174,220,663)
Transfers between reserves		8	(8)	-	-
Comprehensive net expenditure for the year		**(174,220,655)**	**(8)**	**-**	**(174,220,663)**
Grant in Aid		176,716,461			176,716,461
Balance at 31 March 2024		**(8,020,187)**	**2,230**	**-**	**(8,017,957)**

The general fund is used in public sector accounting to reflect the total assets less liabilities of an entity, which are not assigned to another reserve.

Other reserves in the parent relate to fair value losses on equity investments designated as fair value through other comprehensive income under IFRS 9.

The notes on pages 131 to 174 form part of this statement.

Statement of cash flows for the year ended 31 March 2025

		Parent		Consolidated group	
Cash flows from operating activities	**Note**	**2024/25 £000**	**2023/24 £000**	**2024/25 £000**	**2023/24 £000**
Net expenditure for the financial year		(190,840,037)	(174,612,218)	(190,707,580)	(174,220,663)
Depreciation and amortisation	4	286,658	301,876	329,136	348,475
Impairments and reversals	4	-	-	-	592
Other non-cash adjustments		(52)	6	(607)	(256)
Movement due to transfers by absorption	12	-	(193,105)	(1,077)	(193,105)
Interest paid		3,248	1,644	10,031	(1,522)
(Gain)/Loss on disposal		1,323	2,233	1,890	596
Unwinding of discount	13	11,373	14,489	11,454	14,484
Change in discount rate	13	(1,949)	(47,571)	(2,007)	(47,577)
(Increase)/decrease in inventories	8	320	7,810	(13,434)	14,445
(Increase)/decrease in trade & other receivables	9	(40,274)	238,150	(47,091)	213,058
Increase/(decrease) in trade & other payables	11	(402,679)	(2,336,081)	(485,385)	(2,090,574)
Provisions utilised	14	(47,465)	(11,008)	(113,551)	(41,066)
Increase/(decrease) in provisions	14	13,847	(52,982)	41,398	(24,725)
Net cash outflow from operating activities		**(191,015,687)**	**(176,686,757)**	**(190,976,823)**	**(176,027,838)**
Cash flows from investing activities					
Interest received		-	-	20	18
Payments for property, plant and equipment		(10,832)	(102,781)	(23,525)	(123,767)
Payments for intangible assets		(252,063)	(167,377)	(253,269)	(167,803)
Proceeds for other financial assets		-	-	-	1,927
Proceeds from disposal of assets: property, plant and equipment		-	253	441	2,372
Net cash outflow from investing activities		**(262,895)**	**(269,905)**	**(276,333)**	**(287,253)**
Net cash outflow before financing activities		**(191,278,582)**	**(176,956,662)**	**(191,253,156)**	**(176,315,091)**
Cash flows from financing activities					
Grant in aid funding received	SoCTE	191,442,374	176,716,461	191,442,374	176,716,461
Other loans received		-	-	115,000	50,000
Other loans repaid		-	-	(126,295)	(745,356)
Repayment of Lease Liability		(24,622)	(26,439)	(54,675)	(59,867)
Cash Transferred under absorption	12	-	178,171	1,077	178,171
Net cash inflow from financing activities		**191,417,752**	**176,868,193**	**191,377,481**	**176,139,409**
Net increase (decrease) in cash & cash equivalents		**139,170**	**(88,469)**	**124,325**	**(175,682)**
Cash & Cash Equivalents at the Beginning of the Financial Year	10	286,416	374,885	408,621	584,303
Cash & Cash Equivalents at the end of the Financial Year	**10**	**425,586**	**286,416**	**532,946**	**408,621**

The notes on pages 131 to 174 form part of this statement.

There is no separate disclosure under IAS 7 for cash and non-cash movements for financing activities because the values are immaterial.

Notes to the financial statements

1. Statement of accounting policies

These financial statements have been prepared in a form directed by the Secretary of State under Schedule 1(A), paragraph 15(2) of the NHS Act 2006 (as amended by the Health and Care Act 2022) and in accordance with the FReM 2024/25 issued by HM Treasury and the DHSC Group Accounting Manual (GAM) issued by the Department of Health & Social Care. The accounting policies contained in the FReM and the DHSC GAM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM or the DHSC GAM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of NHS England for the purpose of giving a true and fair view has been selected. The particular policies adopted by NHS England are described below. They have been applied consistently in dealing with items considered material to the accounts.

The functional and presentational currency is pounds sterling and figures are expressed in pounds thousands unless expressly stated. Two sets of figures are presented – the first relating to NHS England itself (the Parent) and a second set of consolidated figures (Consolidated Group). The entities making up the Consolidated Group are declared in Note 22.

Exchange gains and losses on monetary items (arising on settlement of the transaction or on retranslation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Net Expenditure in the period in which they arise.

1.1 Operating segments

Income and expenditure are analysed in the Operating Segments note (note 18) and reflect the management information used within NHS England. Information on assets less liabilities is not separately reported to the function equivalent to the Chief Operating Decision Maker and therefore in accordance with IFRS 8 does not form part of the disclosure in note 18.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention, modified to account for the revaluation of property, plant and equipment, intangible assets, and certain financial assets and financial liabilities.

1.3 Basis of consolidation

These accounts comprise the results of the NHS England statutory entity as well as the consolidated position of NHS England, 42 ICBs and SCCL. Transactions between entities included in the consolidation are eliminated.

CSUs form part of NHS England and provide services to ICBs. The CSU results are included within the Parent accounts as they are not separate legal entities.

1.4 Comparative information

The comparative information provided in these financial statements is for the year ended 31 March 2024.

1.5 Going concern

NHS England's financial statements are produced on a going concern basis. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents. NHS England is financed by grant-in-aid and draws its funding from the DHSC. Parliament has demonstrated its commitment to fund the DHSC for the foreseeable future via the latest Spending Review and the passing of the Health and Care Act 2022.

On 13 March 2025 the government announced NHS England and the DHSC will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. Primary legislation will be required to integrate and effect the demise of the statutory entity NHS England. The date of demise cannot be determined at this time however as noted above public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. If services continue to be provided in the public sector the financial statements are prepared on the going concern basis. The current assessment is that in the absence of a detailed plan to the contrary, services in line with The Act will continue to be provided. The statement of financial position has therefore been drawn up at 31 March 2025, on a going concern basis.

1.6 Transfer of functions

As public sector bodies within a Departmental Boundary are deemed to operate under common control, business reconfigurations are outside the scope of IFRS 3 Business Combinations. When functions transfer between two public sector bodies the FReM requires the application of "absorption accounting". Absorption accounting requires that entities account for their transactions in the period in which those transactions took place. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Net Comprehensive Expenditure and is disclosed separately from operating costs.

1.7 Revenue recognition

In the application of IFRS 15 a number of practical expedients have been employed.
These are as follows:

- NHS England is not required to disclose information regarding performance obligations that are part of a contract that has an original expected duration of one year or less.
- NHS England is not required to disclose information where revenue is recognised in line with the practical expedient offered in the Standard, where the right to consideration corresponds directly with the value of the performance completed to date.

The main source of funding for NHS England is grant-in-aid from the Department of Health & Social Care. NHS England is required to maintain expenditure within this allocation.
The Department of Health & Social Care also approves a cash limit for the period.
NHS England is required to draw down cash in accordance with this limit.

Grant-in-aid is drawn down and credited to the general fund. Grant-in-aid is recognised in the financial period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transaction price allocated to that performance obligation.

IFRS 15 is applicable to revenue in respect of dental and prescription charges in line with the adaptation in IFRS 15 which states that the definition of a contract includes revenue received under legislation and regulations. Revenue for these charges is recognised when the performance event occurs, such as the issue of a prescription or payment for dental treatment.

Income received in respect of penalty charge notices issued in relation to non-payment of prescribing and dental charges is recognised on a cash receipts basis.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Other operating revenue is recognised when the service is rendered and the stage completion of the transaction at the end of the reporting period can be measured reliably, and it is probable that the economic benefit associated with the transaction will flow to the group. Income is measured at fair value of the consideration receivable.

The value of the benefit received when NHS England accesses funds from the government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.8 Employee benefits

Recognition of short-term benefits – retirement benefit costs:

Past and present employees are covered by the provisions of the NHS Pensions schemes. The schemes are unfunded, defined benefit schemes that cover NHS employers, general practitioners and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying assets and liabilities. Therefore, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

For early retirements other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the organisation commits itself to the retirement, regardless of the method of payment.

Salaries, wages and employment related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following year.

1.9 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

The provision of funding to group bodies by the NHS England parent matches the recipient's cash needs and is accounted for on a cash basis in the period in which it is paid.
These payments finance ICBs' operating expenditure. These transactions are eliminated at the NHS England group level as indicated in Note 4.

1.10 Value added tax

Most of the activities of the group are outside the scope of value added tax (VAT).
Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.11 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the group
- it is expected to be used for more than 1 financial year
- the cost of the item can be measured reliably; and either
- the item cost at least £5,000, or
- collectively, a number of items have a total cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

Where an asset includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their individual useful economic lives.

Measurement of property, plant and equipment

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historical cost as a proxy for current value in existing use. This is in accordance with FReM requirements as these assets have short useful lives or low values or both.

Balances held in the Revaluation reserve relate to balances inherited from 1 April 2013. In line with our accounting policy, no further revaluation gains have been recognised.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is charged to operating expenses.

1.12 Intangible non-current assets

Intangible non-current assets are non-monetary assets without physical substance that are capable of sale separately from the rest of the group's business or arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the group; where the cost of the asset can be measured reliably; and where the cost is at least £5,000 or collectively the cost is at least £5,000 with each individual item costing more than £250.

Intangible non-current assets acquired separately are initially recognised at cost. Software that is integral to the operation of hardware is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware is capitalised as an intangible asset.

Following initial recognition, intangible assets are carried at depreciated historic cost as a proxy for current value in existing use.

1.13 Research and development

Expenditure on research is not capitalised; it is recognised as an operating expense in the period in which it is incurred.

Internally generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial, and other resources to complete the intangible asset and sell or use it
- the ability to reliably measure the expenditure attributable to the intangible asset during its development.

The amount initially recognised for internally generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

1.14 Depreciation, amortisation and impairments

Freehold land, assets under construction, investment properties, stockpiled goods and assets held for sale are neither depreciated nor amortised.

Otherwise, depreciation or amortisation, as appropriate, is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight-line basis over their estimated remaining useful lives. The estimated useful life of an asset is the period over which economic benefits or service potential is expected to be obtained from the asset. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

Depreciation/amortisation is charged as follows:

	Minimum life (years)	Maximum life (years)
Buildings excluding dwellings	5	20
Plant and machinery	5	10
Transport equipment	5	10
Information technology	2	10
Furniture and fittings	5	10
Computer software: purchased	2	5
Licences and trademarks	2	5
Development expenditure (internally generated)	2	5

1.15 Government grant funded assets

Government grant funded assets are capitalised at their fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.16 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.

IFRS 16 Leases was effective across the public sector from 1 April 2022. The transition to IFRS 16 was completed in accordance with paragraph C5 (b) of the Standard, applying IFRS 16 requirements retrospectively recognising the cumulative effects at the date of initial application.

In the transition to IFRS 16 a number of elections and practical expedients offered in the Standard were employed. These were as follows:

NHS England has applied the practical expedient offered in the Standard per paragraph C3 to apply IFRS 16 to contracts or arrangements previously identified as containing a lease under the previous leasing standards IAS 17 Leases and IFRIC 4 Determining whether an Arrangement contains a Lease and not to those that were identified as not containing a lease under previous leasing standards.

On initial application NHS England has measured the right of use assets for leases previously classified as operating leases per IFRS 16 C8 (b)(ii), at an amount equal to the lease liability adjusted for accrued or prepaid lease payments.

No adjustments have been made for operating leases in which the underlying asset is of low value per paragraph C9 (a) of the Standard.

The transitional provisions were not applied to operating leases whose terms end within 12 months of the date of initial application has been employed per paragraph C10 (c) of IFRS 16.

Hindsight was used to determine the lease term when contracts or arrangements contain options to extend or terminate the lease in accordance with C10 (e) of IFRS 16.

Due to transitional provisions employed the requirements for identifying a lease within paragraphs 9 to 11 of IFRS 16 was not employed for leases in existence at the initial date of application. Leases entered into on or after 1 April 2022 will be assessed under the requirements of IFRS 16.

There are further expedients or elections that have been employed by NHS England in applying IFRS 16. These include:

The measurement requirements under IFRS 16 are not applied to leases with a term of 12 months or less under paragraph 5 (a) of IFRS 16.

The measurement requirements under IFRS 16 are not applied to leases where the underlying asset is of a low value which are identified as those assets of a value of less than £5,000, excluding any irrecoverable VAT, under paragraph 5 (b) of IFRS 16.

NHS England will not apply IFRS 16 to any new leases of intangible assets applying the treatment described in section 1.12 instead.

HM Treasury have adapted the public sector approach to IFRS 16 which impacts on the identification and measurement of leasing arrangements that will be accounted for under IFRS 16.

NHS England is required to apply IFRS 16 to lease like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. Prior to accounting for such arrangements under IFRS 16 NHS England has assessed that in all other respects these arrangements meet the definition of a lease under the Standard.

NHS England is required to apply IFRS 16 to lease like arrangements entered into in which consideration exchanged is nil or nominal, therefore significantly below market value. These arrangements are described as peppercorn leases. Such arrangements are again required to meet the definition of a lease in every other respect prior to inclusion in the scope of IFRS 16. The accounting for peppercorn arrangements aligns to that identified for donated assets. Peppercorn leases are different in substance to arrangements in which consideration is below market value but not significantly below market value.

The nature of the accounting policy change for the lessee is more significant than for the lessor under IFRS 16. IFRS 16 introduces a singular lessee approach to measurement and classification in which lessees recognise a right of use asset.

For the lessor leases remain classified as finance leases when substantially all the risks and rewards incidental to ownership of an underlying asset are transferred to the lessee. When this transfer does not occur, leases are classified as operating leases.

1.16.1 NHS England as a lessee

At the commencement date for the leasing arrangement a lessee shall recognise a right of use asset and corresponding lease liability. NHS England employs a revaluation model for the subsequent measurement of its right of use assets unless cost is considered to be an appropriate proxy for current value in existing use or fair value in line with the accounting policy for owned assets. Where consideration exchanged is identified as below market value, cost is not considered to be an appropriate proxy to value the right of use asset.

Lease payments are apportioned between finance charges and repayment of the principal. Finance charges are recognised in the Statement of Comprehensive Net Expenditure. Irrecoverable VAT is expensed in the period to which it relates and therefore not included in the measurement of the lease liability and consequently the value of the right of use asset.

The incremental borrowing rate of 0.95% has been applied to the lease liabilities recognised at the date of initial application of IFRS 16. Where changes in future lease payments result from a change in an index or rate or rent review, the lease liabilities are remeasured using an unchanged discount rate.

Where there is a change in a lease term or an option to purchase the underlying asset NHS England applies a revised rate to the remaining lease liability.

Where existing leases are modified NHS England must determine whether the arrangement constitutes a separate lease and apply the Standard accordingly.

Where an implicit rate cannot be determined, the incremental borrowing rate determined by HM Treasury annually is applied. A nominal rate of 3.51% applied to new leases commencing in 2023 and 4.72% to new leases commencing in 2024.

Lease payments are recognised as an expense on a straight-line or another systematic basis over the lease term, where the lease term is in substance 12 months or less or is elected as a lease containing low value underlying asset by NHS England.

1.17 Inventories

Inventories are valued at the lower of cost and net realisable value and are utilised using the First in First Out method of inventory controls.

1.18 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and are readily convertible to known amounts of cash with insignificant risk of change in value.

In the statement of cash flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of cash management. Cash, bank and overdraft balances are recorded at current values.

1.19 Provisions

Provisions are recognised when there exists a present legal or constructive obligation as a result of a past event, it is probable that the group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury’s discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of 2.40 percent (2023/24: 2.45 percent) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- a nominal short-term rate of 4.03 percent (2023/24: 4.26 percent in real terms) is applied to inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date
- a nominal medium-term rate of 4.07 percent (2023/24: 4.03 percent in real terms) is applied to inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date
- a nominal, long-term rate of 4.810 percent (2023/24: 4.72 percent in real terms) is applied to inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date
- a nominal very long-term rate of 4.55 percent (2023/24: 4.40 percent) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

1.20 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which NHS England and ICBs pay an annual contribution to NHS Resolution, which in turn settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability rests with the group.

1.21 Non-clinical risk pooling

The NHS England group participates in the Property Expenses Scheme and the Liabilities to Third Parties scheme. Both are risk pooling schemes under which NHS England and ICBs pay an annual contribution to NHS Resolution and, in return, receive assistance with the cost of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims, are charged to operating expenses when they become due.

1.22 Contingent liabilities and contingent assets

A contingent liability is:

- a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the organisation
- a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation, or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the organisation. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities that are required to be disclosed under IAS37 are stated at discounted amounts.

1.23 Financial assets

Financial assets are recognised on the statement of financial position when the group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired, or the asset has been transferred, and the group has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

As available for sale financial assets, the group's investments are measured at fair value. With the exception of impairment losses, changes in value are taken to the revaluation reserve. Accumulated gains or losses are recycled to the consolidated statement of net comprehensive expenditure on de- recognition.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.23.1 Financial assets at amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.23.2 Financial assets at fair value through other comprehensive income

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.23.3 Financial assets at fair value through profit and loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.23.4 Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, NHS England recognises a loss allowance representing expected credit losses on the financial instrument.

NHS England adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. NHS England therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the DHSC provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and NHS England does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.24 Financial liabilities

Financial liabilities are recognised in the statement of financial position when the group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged; that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

After initial recognition, financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.25 Accounting standards that have been issued but have not yet been adopted

The FReM does not require the following Standards and Interpretations to be applied in 2024/25. These standards are still subject to HM Treasury FReM adoption.

IFRS 17 Insurance Contracts is yet to be adopted by the FReM.
Application is from 1 April 2025 and the standard has not yet been adopted.

The NHS England group will therefore apply IFRS 17 for the first time in the 2025/26 financial year with 1 April 2024 being the transition date. IFRS 17 will require entities to apply the standard retrospectively and work is underway to determine the impact of the new standard. This work is in its early stages with NHS England and its group entities currently in the process of identifying any contracts that meet the criteria for an insurance contract under IFRS 17. Until this work is completed it is not possible to provide detailed information on the impact of IFRS 17, although preliminary indications are that it would not be material.

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK-endorsed and not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK-endorsed and not yet adopted by the FReM: early adoption is not therefore permitted.

2. Operating income

	Parent		Consolidated group	
Income from sale of goods and services (contracts)	**2024/25 £000**	**2023/24 £000**	**2024/25 £000**	**2023/24 £000**
Education, training and research	11,499	15,459	18,014	17,748
Non-patient care services to other bodies	449,663	399,727	4,437,923	3,927,300
Prescription fees and charges[179]	-	(596)	730,413	693,188
Dental fees and charges[179]	-	9,398	796,508	777,479
Other contract income	146,115	122,547	332,756	333,954
Recoveries in respect of employee benefits	459	(120)	4,028	4,925
Total income from sale of goods and services	**607,736**	**546,415**	**6,319,642**	**5,754,594**
Other operating income				
Rental revenue from finance leases	-	-	21	40
Rental revenue from operating leases	-	-	1,007	991
Charitable and other contributions to revenue expenditure: non-NHS	150	57	848	796
Receipt of donations (capital/cash)[180]	-	-	-	(1,927)
Receipt of Government grants for capital acquisitions	-	-	-	1
Non-cash apprenticeship training grants revenue	1,470	1,295	2,220	1,917
Other non-contract revenue	1,762	4,407	88,088	123,011
Total other operating income	**3,382**	**5,759**	**92,184**	**124,829**
Total operating income	**611,118**	**552,174**	**6,411,826**	**5,879,423**

Intercompany trading is eliminated between bodies within the NHS England group upon consolidation.

[179] In line with the adaptation in the HM Treasury Financial Reporting Manual prescription fees and charges and dental fees and charges are treated as revenue arising from a contract and accounted for under IFRS15.
[180] The receipts of donation(capital/cash) in the parent is in relation to donated imaging assets from Department of Health and Social Care.

2.1 Disaggregation of revenue

We disaggregate our revenue from contracts with customers by the nature of the revenue. This is shown in Note 2. Note 2.1 provides the disaggregation in line with our operating segments reported in Note 18.

Income from sale of goods and services (contracts)

Parent 2024/25	ICB £000	SCCL £000	Direct commissioning £000	NHS England £000	Multi-Professional Education and Training Investment Plan £000	Other £000	Intercompany eliminations £000	Total £000
Income from sale of goods and services (contracts)								
Education, training and research	-	-	-	9,880	1,654	-	(35)	**11,499**
Non-patient care services to other bodies	-	-	2,167	166,087	152	476,233	(194,976)	**449,663**
Prescription fees and charges	-	-	-	-	-	-	-	**-**
Dental fees and charges	-	-	-	-	-	-	-	**-**
Other contract income	-	-	24,974	74,967	241	14,374	31,559	**146,115**
Recoveries in respect of employee benefits	-	-	1	431	27	-	-	**459**
Total income from sale of goods and services	**-**	**-**	**27,142**	**251,365**	**2,074**	**490,607**	**(163,452)**	**607,736**

Parent 2023/24	ICB £000	SCCL £000	Direct commissioning £000	NHS England £000	Multi-Professional Education and Training Investment Plan £000	Other £000	Intercompany eliminations £000	Total £000
Income from sale of goods and services (contracts)								
Education, training and research	-	-	-	10,562	4,786	-	111	**15,459**
Non-patient care services to other bodies	-	-	1,429	89,392	169	495,727	(186,990)	**399,727**
Prescription fees and charges	-	-	(596)	-	-	-	-	**(596)**
Dental fees and charges	-	-	5,512	-	-	3,886	-	**9,398**
Other contract income	-	-	21,401	44,214	252	14,699	41,981	**122,547**
Recoveries in respect of employee benefits	-	-	-	(109)	(27)	-	16	**(120)**
Total income from sale of goods and services	**-**	**-**	**27,746**	**144,059**	**5,180**	**514,312**	**(144,882)**	**546,415**

Consolidated group 2024/25	ICB £000	SCCL £000	Direct commissioning £000	NHS England £000	Multi-Professional Education and Training Investment Plan £000	Other £000	Intercompany eliminations £000	Total £000
Income from sale of goods and services (contracts)								
Education, training and research	9,676	-	-	9,880	1,654	-	(3,196)	**18,014**
Non-patient care services to other bodies	264,993	4,293,437	2,167	166,087	152	476,233	(765,146)	**4,437,923**
Prescription fees and charges	730,413	-	-	-	-	-	-	**730,413**
Dental fees and charges	796,508	-	-	-	-	-	-	**796,508**
Other contract income	176,640	-	24,974	74,967	241	14,374	41,560	**332,756**
Recoveries in respect of employee benefits	4,687	-	1	431	27	-	(1,118)	**4,028**
Total income from sale of goods and services	**1,982,917**	**4,293,437**	**27,142**	**251,365**	**2,074**	**490,607**	**(727,900)**	**6,319,642**

Consolidated group 2023/24	ICB £000	SCCL £000	Direct commissioning £000	NHS England £000	Multi-Professional Education and Training Investment Plan £000	Other £000	Intercompany eliminations £000	Total £000
Income from sale of goods and services (contracts)								
Education, training and research	7,499	-	-	10,562	4,786	-	(5,099)	**17,748**
Non-patient care services to other bodies	320,338	3,787,421	1,429	89,392	169	495,727	(767,176)	**3,927,300**
Prescription fees and charges	693,784	-	(596)	-	-	-	-	**693,188**
Dental fees and charges	768,082	-	5,512	-	-	3,885	-	**777,479**
Other contract income	231,468	-	21,401	44,214	252	14,699	21,920	**333,954**
Recoveries in respect of employee benefits	6,036	-	-	(109)	(27)	-	(975)	**4,925**
Total income from sale of goods and services	**2,027,207**	**3,787,421**	**27,746**	**144,059**	**5,180**	**514,311**	**(751,330)**	**5,754,594**

3. Employee benefits

3.1. Employee benefits table

	Parent		Consolidated group	
Employee benefits	**2024/25 £000**	**2023/24 £000**	**2024/25 £000**	**2023/24 £000**
Salaries and wages	1,343,475	1,416,905	2,790,181	2,830,323
Social security costs	143,391	150,016	299,626	298,439
Employer contributions to NHS Pension scheme	267,382	232,638	550,490	465,664
Other pension costs	-	-	6,516	4,810
Apprenticeship levy	6,308	6,321	12,503	12,330
Termination benefits	8,113	2,789	10,109	85,946
Gross employee benefits expenditure	**1,768,669**	**1,808,669**	**3,669,425**	**3,697,512**
Less: Employee costs capitalised	(8,905)	(11,272)	(8,905)	(11,272)
Gross employee benefits excluding capitalised costs	**1,759,764**	**1,797,397**	**3,660,520**	**3,686,240**
Less recoveries in respect of employee benefits	(459)	120	(4,028)	(4,925)
Net employee benefits	**1,759,305**	**1,797,517**	**3,656,492**	**3,681,315**

Staff numbers can be found in the Accountability Report on page 87

3.2 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period. In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

3.2.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

3.2.2 Principal Civil Service Pension Scheme

Past and present employees are covered by the provisions of the Principal Civil Service Pension Scheme and the Civil Servant and Other Pension Scheme. These schemes are unfunded, defined benefit schemes covering civil servants. The schemes are not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to NHS England of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For defined contribution schemes, such as Civil Service partnership pensions, NHS England recognises the contributions payable for the year.

NHS England recognises the full cost of benefits paid under the Civil Service Compensation Scheme, including the early payment of pensions.

4. Operating expenses

	Parent 2024/25 £000	Parent 2023/24 £000	Consolidated group 2024/25 £000	Consolidated group 2023/24 £000
Purchase of goods and services – cash				
Services from other ICBs and NHS England	3,612	21,116	-	-
Services from foundation trusts	20,299,506	21,701,442	86,707,407	78,843,886
Services from other NHS trusts	7,987,170	8,614,110	40,285,209	36,972,464
Services from other Whole of Government Accounts (WGA) bodies[181]	15,937	7,051	87,544	72,799
Purchase of healthcare from non-NHS bodies	1,185,360	946,909	20,363,312	18,107,862
Purchase of social care	-	-	1,325,063	1,196,487
General dental services and personal dental services	92,751	(89,039)	3,718,746	3,108,156
Prescribing costs	-	(6,565)	10,547,895	10,345,592
Pharmaceutical services	146,907	158,761	2,242,177	2,146,218
General ophthalmic services	4,868	(5,905)	655,046	614,432
GP primary care services	971,170	770,452	13,681,967	12,575,592
Supplies and services – clinical	(511,462)	(478,799)	(430,936)	(419,427)
Supplies and services – general	690,752	731,266	1,884,122	1,773,671
Consultancy services	16,886	17,146	48,363	56,457
Establishment	845,103	626,527	1,159,875	920,755
Transport	8,764	9,555	132,488	108,673
Premises	37,080	39,470	352,693	349,920
Audit fees[182]	1,110	820	12,546	12,707
Other non-statutory audit expenditure	-	-	3,574	3,704
Other professional fees	371,550	297,424	460,547	385,126
Legal fees	15,238	11,737	47,552	35,271
Education and training	143,044	52,118	174,637	84,213
Multi-Professional Education and Training Investment Plan Expenditure	5,797,024	5,396,741	5,777,263	5,361,318
Funding to group bodies[183]	151,026,114	134,068,351	-	-
Total purchase of goods and services - cash	**189,148,484**	**172,890,688**	**189,237,090**	**172,655,876**
Other operating expenditure - cash				
Chair and non-executive members	173	152	7,718	7,855
Grants to other bodies	215,976	112,420	234,003	129,276
Clinical negligence	-	-	168	223
Research and development (excluding staff costs)	225	1,463	22,037	21,525
Other expenditure	17,267	30,599	21,645	47,721
Other operating expenditure - cash	**233,641**	**144,634**	**285,571**	**206,600**
Total operating expenses - cash	**189,382,125**	**173,035,322**	**189,522,661**	**172,862,476**

[181] Services from other WGA bodies comprises expenditure with the DHSC, DHSC arm's length bodies and NHS Blood and Transplant.
[182] Of the total audit fees in the parent entity £640k relates to the NHS England audit and £470k to the Consolidated Provider Account audit. In both financial years NHS England purchased no non-audit services from NAO. Details of ICB audit fees and non-audit expenditure can be found in the underlying individual ICB accounts.
[183] Funding to group bodies is shown above and represents cash funding drawn down by the ICBs. These balances are eliminated on consolidation.

Depreciation and impairment charges - non cash items	Parent 2024/25 £000	Parent 2023/24 £000	Consolidated group 2024/25 £000	Consolidated group 2023/24 £000
Depreciation	153,703	169,068	191,326	213,876
Amortisation	132,955	132,808	137,810	134,599
Impairments and reversals of right-of-use-assets	-	-	-	592
Total depreciation and impairment charges	**286,658**	**301,876**	**329,136**	**349,067**
Provision expense – non-cash items				
Change in discount rate	(1,949)	(47,571)	(2,007)	(47,577)
Provisions	7,046	(61,976)	40,538	(77,865)
Total provision expense	**5,097**	**(109,547)**	**38,531**	**(125,442)**
Purchase of goods and services – non-cash				
Non-cash apprenticeship training grants	1,470	1,295	2,220	1,917
Total purchase of goods and services – non-cash	**1,470**	**1,295**	**2,220**	**1,917**
Other operating expenditure – non-cash items				
Expected credit loss on receivables	(2,003)	12,817	33,475	19,930
Inventories written down	-	1,046	1,913	3,010
Inventories consumed	625	7,306	3,506,433	3,181,494
Total other operating expenditure	**(1,378)**	**21,169**	**3,541,821**	**3,204,434**
Total other operating expenses – non-cash	**291,847**	**214,793**	**3,911,708**	**3,429,976**
Total operating expenditure excluding employee benefits	**189,673,972**	**173,250,115**	**193,434,369**	**176,292,452**

Intercompany trading is eliminated between bodies within the NHS England group upon consolidation.

5. Property, plant, and equipment

Parent 2024/25	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation at 1 April 2024	**1,627**	**1,119**	**2,577**	**591**	**876,033**	**31,489**	**913,436**
Additions purchased	-	-	105	-	89,807	2,084	**91,996**
Disposals	(1,294)	-	(469)	(591)	(260,551)	(1,748)	**(264,653)**
Cost or valuation at 31 March 2025	**333**	**1,119**	**2,213**	**-**	**705,289**	**31,825**	**740,779**
Depreciation 1 April 2024	**1,461**	**-**	**908**	**591**	**552,245**	**8,226**	**563,431**
Disposals	(1,294)	-	(469)	(591)	(260,551)	(1,748)	**(264,653)**
Charged during the year	81	-	469	-	128,012	3,157	**131,719**
At 31 March 2025	**248**	**-**	**908**	**-**	**419,706**	**9,635**	**430,497**
Asset financing:							
Owned	85	1,119	1,305	-	278,818	22,190	**303,517**
Donated	-	-	-	-	6,765	-	**6,765**
Total at 31 March 2025	**85**	**1,119**	**1,305**	**-**	**285,583**	**22,190**	**310,282**

Parent 2023/24	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation at 1 April 2023	**113**	**-**	**470**	**591**	**875,912**	**29,392**	**906,478**
Additions purchased	-	-	825	-	81,862	4,683	**87,370**
Additions donated	-	-	-	-	-	-	**-**
Reclassifications	(166)	-	-	-	(2,614)	(236)	**(3,016)**
Disposals	(365)	-	-	-	(79,254)	(2,629)	**(82,248)**
Transfer (to)/from other public sector body	2,045	1,119	1,282	-	127	279	**4,852**
Cost or valuation at 31 March 2024	**1,627**	**1,119**	**2,577**	**591**	**876,033**	**31,489**	**913,436**
Depreciation 1 April 2023	**113**	**-**	**462**	**581**	**486,880**	**8,246**	**496,282**
Reclassifications	(166)	-	224	-	242	(13)	**287**
Disposals	(365)	-	-	-	(77,095)	(2,617)	**(80,077)**
Charged during the year	406	-	196	10	141,990	2,505	**145,107**
Transfer (to)/from other public sector body	1,473	-	26	-	228	105	**1,832**
At 31 March 2024	**1,461**	**-**	**908**	**591**	**552,245**	**8,226**	**563,431**
Carrying value at 31 March 2024	**166**	**1,119**	**1,669**	**-**	**323,788**	**23,263**	**350,005**
Asset financing:							
Owned	166	1,119	1,669	-	312,190	23,263	**338,407**
Donated	-	-	-	-	11,598	-	**11,598**
Total at 31 March 2024	**166**	**1,119**	**1,669**	**-**	**323,788**	**23,263**	**350,005**

Consolidated group 2024/25	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation at 1 April 2024	**23,830**	**34,309**	**12,391**	**694**	**923,469**	**43,793**	**1,038,486**
Addition of assets under construction and payments on account	-	6,573	-	-	-	-	**6,573**
Additions purchased	557	-	10,426	-	91,720	2,226	**104,929**
Reclassifications	-	(39,763)	-	-	758	4,929	**(34,076)**
Disposals	(1,294)	-	(4,702)	(591)	(267,152)	(3,047)	**(276,786)**
Transfer (to)/from other public sector body	-	-	-	-	-	-	**-**
Cost or valuation at 31 March 2025	**23,093**	**1,119**	**18,115**	**103**	**748,795**	**47,901**	**839,126**
Depreciation 1 April 2024	**5,517**	**-**	**9,453**	**694**	**588,875**	**15,025**	**619,564**
Disposals	(1,292)	-	(4,329)	(591)	(267,167)	(3,045)	**(276,424)**
Charged during the year	2,010	-	1,793	-	131,870	4,442	**140,115**
Transfer (to)/from other public sector body	-	-	-	-	-	-	**-**
At 31 March 2025	**6,235**	**-**	**6,917**	**103**	**453,578**	**16,422**	**483,255**
Carrying Value at 31 March 2025	**16,858**	**1,119**	**11,198**	**-**	**295,217**	**31,479**	**355,871**
Asset financing:							
Owned	16,858	1,119	11,198	-	288,452	31,479	**349,106**
Donated	-	-	-	-	6,765	-	**6,765**
Total at 31 March 2025	**16,858**	**1,119**	**11,198**	**-**	**295,217**	**31,479**	**355,871**

Consolidated group 2024/25	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation at 1 April 2023	**7,884**	**35,820**	**10,338**	**694**	**955,800**	**42,170**	**1,052,706**
Addition of assets under construction and payments on account	-	16,775	-	-	-	-	**16,775**
Additions purchased	-	-	825	-	84,067	5,495	**90,387**
Reclassifications	14,266	(19,405)	-	-	(12,565)	86	**(17,618)**
Disposals	(365)	-	(54)	-	(103,960)	(4,237)	**(108,616)**
Transfer (to)/from other public sector body	2,045	1,119	1,282	-	127	279	**4,852**
Cost or valuation at 31 March 2024	**23,830**	**34,309**	**12,391**	**694**	**923,469**	**43,793**	**1,038,486**
Depreciation 1 April 2023	**2,871**	**-**	**8,221**	**684**	**543,893**	**15,720**	**571,389**
Reclassifications	(166)	-	224	-	(2,253)	(13)	**(2,208)**
Disposals	(365)	-	(54)	-	(101,795)	(4,225)	**(106,439)**
Charged during the year	1,704	-	1,036	10	148,802	3,438	**154,990**
Transfer (to)/from other public sector body	1,473	-	26	-	228	105	**1,832**
At 31 March 2024	**5,517**	**-**	**9,453**	**694**	**588,875**	**15,025**	**619,564**
Carrying value at 31 March 2024	**18,313**	**34,309**	**2,938**	**-**	**334,594**	**28,768**	**418,992**
Asset financing:							
Owned	18,313	34,309	2,938	-	322,996	28,768	**407,324**
Donated	-	-	-	-	11,598	-	**11,598**
Total at 31 March 2024	**18,313**	**34,309**	**2,938**	**-**	**334,594**	**28,768**	**418,922**

6. Right-of-use assets

6.1 Right-of-use assets

Parent 2024/25	Land £000	Buildings excluding dwellings £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 01 April 2024	**-**	**155,645**	**-**	**472**	**10,965**	**-**	**167,082**
Additions	-	1,582	-	215	10,162	-	**11,959**
ROU Dilapidation	-	402	-	-	-	-	**402**
Lease remeasurement	-	6,469	-	18	(618)	-	**5,869**
Disposals on expiry of lease term	-	(7,980)	-	-	-	-	**(7,980)**
Derecognition for early terminations	-	(587)	-	-	(505)	-	**(1,092)**
Cost/Valuation at 31 March 2025	**-**	**155,531**	**-**	**705**	**20,004**	**-**	**176,240**
Depreciation 01 April 2024	**-**	**43,868**	**-**	**291**	**6,145**	**-**	**50,304**
Charged during the year	-	19,255	-	115	2,614	-	**21,984**
Disposals on expiry of lease term	-	(7,980)	-	-	-	-	**(7,980)**
Derecognition for early terminations	-	(216)	-	-	(231)	-	**(447)**
Depreciation at 31 March 2025	**-**	**54,927**	**-**	**406**	**8,528**	**-**	**63,861**
Net Book Value at 31 March 2025	**-**	**100,604**	**-**	**299**	**11,476**	**-**	**112,379**

Parent 2023/24	Land £000	Buildings excluding dwellings £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2023	**-**	**136,300**	**-**	**352**	**12,544**	**-**	**149,196**
IFRS 16 Transition Adjustment	-	-	-	-	-	-	**-**
Additions	-	17,969	-	120	803	-	**18,892**
Reclassifications	-	-	-	-	834	-	**834**
Lease remeasurement	-	(2,855)	-	-	(2,736)	-	**(5,591)**
Modifications	-	(168)	-	-	-	-	**(168)**
Disposals on expiry of lease term	-	(652)	-	-	(412)	-	**(1,064)**
Derecognition for early terminations	-	(1,920)	-	-	(68)	-	**(1,988)**
Transfer (to)/from other public sector body	-	6,971	-	-	-	-	**6,971**
Cost or valuation at 31 Mar 2024	**-**	**155,645**	**-**	**472**	**10,965**	**-**	**167,082**
Depreciation 1 April 2023	**-**	**20,550**	**-**	**178**	**5,010**	**-**	**25,738**
Charged during the year	-	22,103	-	113	1,745	-	**23,961**
Reclassifications	-	-	-	-	(193)	-	**(193)**
Disposals on expiry of lease term	-	(652)	-	-	(390)	-	**(1,042)**
Derecognition for early terminations	-	(674)	-	-	(27)	-	**(701)**
Transfer (to)/from other public sector body	-	2,541	-	-	-	-	**2,541**
Depreciation at 31 March 2024	**-**	**43,868**	**-**	**291**	**6,145**	**-**	**50,304**
Net book value at 31 March 2024	**-**	**111,777**	**-**	**181**	**4,820**	**-**	**116,778**

Consolidated group 2024/25	Land £000	Buildings excluding dwellings £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 01 April 2024	**1,097**	**417,292**	**12**	**1,073**	**11,630**	**85**	**431,189**
Additions	-	17,952	-	215	10,161	7	28,335
ROU Dilapidation	-	1,353	-	-	-	-	1,353
Lease remeasurement	-	10,435	-	18	(618)	-	9,835
Disposals on expiry of lease term	-	(21,819)	-	-	-	(28)	(21,847)
Derecognition for early terminations	-	(10,037)	-	-	(505)	-	(10,542)
Cost/Valuation at 31 March 2025	**1,097**	**415,176**	**12**	**1,306**	**20,668**	**64**	**438,323**
Depreciation 01 April 2024	**187**	**123,108**	**9**	**698**	**6,344**	**66**	**130,412**
Charged during the year	126	48,077	3	234	2,747	24	51,211
Disposals on expiry of lease term	-	(21,812)	-	-	-	(28)	(21,840)
Derecognition for early terminations	-	(5,316)	-	-	(231)	-	(5,547)
Depreciation at 31 March 2025	**313**	**144,057**	**12**	**932**	**8,860**	**62**	**154,236**
Net Book Value at 31 March 2025	**784**	**271,119**	**-**	**374**	**11,808**	**2**	**284,087**

Consolidated group 2023/24	Land £000	Buildings excluding dwellings £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 01 April 2023	**1,003**	**398,339**	**12**	**1,236**	**13,212**	**112**	**413,914**
IFRS 16 Transition Adjustment	-	-	-	-	-	-	**-**
Additions	456	39,505	-	402	972	-	**41,335**
Reclassifications	-	-	-	-	834	-	**834**
Lease remeasurement	-	(2,105)	-	-	(2,736)	(1)	**(4,842)**
Modifications	-	(624)	-	-	-	-	**(624)**
Disposals on expiry of lease term	-	(14,494)	-	(565)	(584)	-	**(15,643)**
Derecognition for early terminations	(362)	(9,951)	-	-	(68)	(26)	**(10,407)**
Impairments charged	-	(349)	-	-	-	-	**(349)**
Transfer (to)/from other public sector body	-	6,971	-	-	-	-	**6,971**
Cost/Valuation at 31 March 2024	**1,097**	**417,292**	**12**	**1,073**	**11,630**	**85**	**431,189**
Depreciation 01 April 2023	**120**	**79,941**	**5**	**873**	**5,200**	**44**	**86,183**
Charged during the year	127	56,471	4	325	1,926	33	**58,886**
Reclassifications	-	-	-	-	(193)	-	**(193)**
Impairments charged	-	243	-	-	-	-	**243**
Disposals on expiry of lease term	-	(12,859)	-	(500)	(562)	-	**(13,921)**
Derecognition for early terminations	(60)	(3,229)	-	-	(27)	(11)	**(3,327)**
Transfer (to)/from other public sector body	-	2,541	-	-	-	-	**2,541**
Depreciation at 31 March 2024	**187**	**123,108**	**9**	**698**	**6,344**	**66**	**130,412**
Net Book Value at 31 March 2024	**910**	**294,184**	**3**	**375**	**5,286**	**19**	**300,777**

6.2 Right of use asset lease liabilities

Parent	2024/25 £'000	2023/24 £'000
Lease liabilities at 01 April	**(124,410)**	**(131,734)**
Additions purchased	(8,150)	(17,675)
Interest expense relating to lease liabilities	(3,250)	(1,643)
Repayment of lease liabilities (including interest)	20,680	26,439
Lease remeasurement	(5,870)	3,894
Disposals on expiry of lease term	-	15
Derecognition for early terminations	628	1,167
Transfer (to)/from other public sector body	-	(4,873)
Other	1	-
Lease liabilities at 31 March	**(120,371)**	**(124,410)**

Consolidated group	2024/25 £'000	2023/24 £'000
Lease liabilities at 01 April	**(308,611)**	**(331,582)**
Additions purchased	(24,495)	(39,451)
Interest expense relating to lease liabilities	(6,071)	(4,189)
Repayment of lease liabilities (including interest)	50,686	59,867
Lease remeasurement	(9,771)	1,866
Modifications	(65)	929
Disposals on expiry of lease term	311	1,520
Derecognition for early terminations	4,571	7,298
Transfer (to)/from other public sector body	-	(4,873)
Other	5	3
Lease liabilities at 31 March	**(293,440)**	**(308,612)**

6.3 Right of use asset lease liabilities - maturity analysis of undiscounted future lease payments

Parent	2024/25 £'000	2023/24 £'000
Within 1 year	(21,533)	(25,263)
Between 1 and 5 years	(50,335)	(65,260)
After 5 years	(51,551)	(57,691)
Balance on 31 March	**(123,419)**	**(148,214)**
Effect of discounting	**3,048**	**23,804**
Included in:		
Current right of use asset lease liabilities	(22,257)	(20,250)
Non-current right of use asset lease liabilities	(98,114)	(104,160)
Balance on 31 March	**(120,371)**	**(124,410)**

Consolidated group	2024/25 £'000	2023/24 £'000
Within 1 year	(48,449)	(54,645)
Between 1 and 5 years	(131,123)	(152,040)
After 5 years	(131,986)	(132,385)
Balance on 31 March	**(311,558)**	**(339,070)**
Effect of discounting	**18,118**	**30,458**
Included in:		
Current right of use asset lease liabilities	(46,672)	(49,485)
Non-current right of use asset lease liabilities	(246,768)	(259,127)
Balance on 31 March	**(293,440)**	**(308,612)**

6.4 Amounts recognised in statement comprehensive net expenditure

Parent	2024/25 £'000	2023/24 £'000
Depreciation expense on right-of-use assets	21,984	23,961
Interest expense on lease liabilities	3,250	1,643
Expense relating to short-term leases	756	365

Consolidated group	2024/25 £'000	2023/24 £'000
Depreciation expense on right-of-use assets	51,210	58,886
Interest expense on lease liabilities	6,071	4,189
Expense relating to short-term leases	1,010	487
Expense relating to variable lease payments not included in the measurement of the lease liability	54	699
Gain/(loss) from sale and leaseback transactions	-	14

6.5 Amounts recognised in statement of cash flows

Parent	2024/25 £'000	2023/24 £'000
Total cash outflow on leases under IFRS 16	24,622	26,439

Consolidated group	2024/25 £'000	2023/24 £'000
Total cash outflow on leases under IFRS 16	54,675	59,867
Total cash outflow for lease payments not included within the measurement of lease liabilities	164	736

7. Intangible non-current assets

Parent 2024/25	Computer software: purchased £000	Development expenditure £000	Payments on Accounts & Assets under construction £000	Websites £000	Total £000
Cost or valuation at 1 April 2024	**69,772**	**666,640**	**83,970**	**9,153**	**829,535**
Additions purchased	1,608	189,239	52,311	-	**243,158**
Additions internally generated	-	8,906	-	-	**8,906**
Reclassifications	(661)	77,876	(75,432)	(1,783)	**-**
Disposals	(24,277)	(48,363)	(8)	-	**(72,648)**
At 31 March 2025	**46,442**	**894,298**	**60,841**	**7,370**	**1,008,951**
Amortisation 1 April 2024	**44,866**	**357,916**	**-**	**6,565**	**409,347**
Disposals	(24,277)	(47,053)	-	-	**(71,330)**
Charged during the year	11,831	121,090	-	34	**132,955**
At 31 March 2025	**32,420**	**431,953**	**-**	**6,599**	**470,972**
Carrying Value at 31 March 2025	**14,022**	**462,345**	**60,841**	**771**	**537,979**
Asset financing:					
Owned	14,022	462,345	60,841	771	**537,979**
Total at 31 March 2025	**14,022**	**462,345**	**60,841**	**771**	**537,979**

Parent 2023/24	Computer software: purchased £000	Development expenditure £000	Payments on Accounts & Assets under construction £000	Websites £000	Total £000
Cost or valuation on 1 April 2023	**75,039**	**612,825**	**-**	**4,127**	**691,991**
Additions purchased	5,016	112,462	36,843	1,784	**156,105**
Additions internally generated	-	10,573	699	-	**11,272**
Reclassifications	1,154	(32,934)	32,289	3,835	**4,344**
Disposals	(11,437)	(35,790)	(117)	(593)	**(47,937)**
Transfer (to)/from another public sector body	-	(496)	14,256	-	**13,760**
On 31 March 2024	**69,772**	**666,640**	**83,970**	**9,153**	**829,535**
Amortisation 1 April 2023	**42,488**	**276,729**	**-**	**3,347**	**322,564**
Reclassifications	33	(1,361)	-	3,396	**2,068**
Disposals	(11,437)	(35,713)	-	(593)	**(47,743)**
Charged during the year	13,782	118,611	-	415	**132,808**
Transfer (to)/from another public sector body	-	(350)	-	-	**(350)**
At 31 March 2024	**44,866**	**357,916**	**-**	**6,565**	**409,347**
Carrying value at 31 March 2024	**24,906**	**308,724**	**83,970**	**2,588**	**420,188**
Asset financing:					
Owned	24,906	308,724	83,970	2,588	**420,188**
Total at 31 March 2024	**24,906**	**308,724**	**83,970**	**2,588**	**420,188**

Consolidated group 2024/25	Computer software: purchased £000	Development expenditure £000	Payments on Accounts & Assets under construction £000	Websites £000	Total £000
Cost or valuation at 1 April 2024	**90,464**	**667,103**	**83,968**	**9,153**	**850,688**
Additions purchased	2,813	189,239	52,311	-	**244,363**
Additions internally generated	-	8,906	-	-	**8,906**
Reclassifications	24,816	77,876	(66,832)	(1,784)	**34,076**
Disposals	(25,039)	(48,363)	(8)	-	**(73,410)**
At 31 March 2025	**93,054**	**894,761**	**69,439**	**7,369**	**1,064,623**
Amortisation 1 April 2024	**50,483**	**358,377**	**-**	**6,564**	**415,424**
Disposals	(25,038)	(47,055)	-	-	**(72,093)**
Charged during the year	16,685	121,091	-	34	**137,810**
At 31 March 2025	**42,130**	**432,413**	**-**	**6,598**	**481,141**
Carrying Value at 31 March 2025	**50,924**	**462,348**	**69,439**	**771**	**583,482**
Asset financing:					
Owned	50,924	462,348	69,439	771	**583,482**
Total at 31 March 2025	**50,924**	**462,348**	**69,439**	**771**	**583,482**

Consolidated group 2023/24	Computer software: purchased £000	Development expenditure £000	Payments on Accounts & Assets under construction £000	Websites £000	Total £000
Cost or valuation on 1 April 2023	**83,360**	**614,374**	**-**	**4,127**	**701,861**
Additions purchased	5,443	112,462	36,841	1,784	**156,530**
Additions internally generated	-	10,573	699	-	**11,272**
Reclassifications	15,756	(32,934)	32,289	3,835	**18,946**
Disposals	(14,095)	(36,876)	(117)	(593)	**(51,681)**
Transfer (to)/from another public sector body	-	(496)	14,256	-	**13,760**
On 31 March 2024	**90,464**	**667,103**	**83,968**	**9,153**	**850,688**
Amortisation 1 April 2023	**46,387**	**278,276**	**-**	**3,347**	**328,010**
Reclassifications	2,528	(1,361)	-	3,396	**4,563**
Disposals	(14,006)	(36,799)	-	(593)	**(51,398)**
Charged during the year	15,574	118,611	-	414	**134,599**
Transfer (to)/from another public sector body	-	(350)	-	-	**(350)**
At 31 March 2024	**50,483**	**358,377**	**-**	**6,564**	**415,424**
Carrying value at 31 March 2024	**39,981**	**308,726**	**83,968**	**2,589**	**435,264**
Asset financing:					
Owned	39,981	308,726	83,968	2,589	**435,264**
Total at 31 March 2024	**39,981**	**308,726**	**83,968**	**2,589**	**435,264**

8. Inventories

Parent 2024/25	Consumables £'000	Loan equipment £'000	Other £'000	Total £'000
Balance at 1 April 2024	**-**	**-**	**1,170**	**1,170**
Additions	-	-	305	305
Inventories recognised as an expense in the period	-	-	(625)	(625)
Balance at 31 March 2025	**-**	**-**	**850**	**850**

Parent 2023/24	Consumables £'000	Loan equipment £'000	Other £'000	Total £'000
Balance at 1 April 2023	**5,197**	**-**	**3,783**	**8,980**
Additions	-	-	542	**542**
Inventories recognised as an expense in the period	(4,151)	-	(3,155)	**(7,306)**
Write-down of inventories (including losses)	(1,046)	-	-	**(1,046)**
Balance at 31 March 2024	**-**	**-**	**1,170**	**1,170**

Consolidated group 2024/25	Consumables £'000	Loan equipment £'000	Other £'000	Total £'000
Balance at 1 April 2024	**138,104**	**13,185**	**8,637**	**159,926**
Additions	3,494,490	18,389	8,901	**3,521,780**
Inventories recognised as an expense in the year	(3,483,142)	(12,082)	(11,209)	**(3,506,433)**
Write-down of inventories (including losses)	(1,913)	-	-	**(1,913)**
Balance at 31 March 2025	**147,539**	**19,492**	**6,329**	**173,360**

Consolidated group 2023/24	Consumables £'000	Loan equipment £'000	Other £'000	Total £'000
Balance at 1 April 2023	**153,530**	**8,260**	**12,581**	**174,371**
Additions	3,147,824	7,924	14,311	**3,170,059**
Inventories recognised as an expense in the period	(3,160,240)	(2,999)	(18,255)	**(3,181,494)**
Write-down of inventories (including losses)	(3,010)	-	-	**(3,010)**
Balance at 31 March 2024	**138,104**	**13,185**	**8,637**	**159,926**

9. Trade and other receivables

	Parent			
	2024/25 Current £000	2024/25 Non-current £000	2023/24 Current £000	2023/24 Non-current £000
NHS receivables: revenue	116,185	-	96,457	-
NHS prepayments	153,533	-	142,754	-
NHS accrued income	3,703	-	1,096	-
NHS non-contract	-	-	266	-
Non-NHS and other WGA receivables: Revenue	185,897	-	239,408	-
Non-NHS and other WGA prepayments	213,961	11,058	203,302	-
Non-NHS and other WGA accrued income	98,678	-	87,520	-
Non-NHS and other WGA non-contract	-	-	-	-
Expected credit loss allowance-receivables	(24,678)	-	(31,193)	-
VAT	51,694	-	29,444	-
Finance lease receivables	-	-	-	-
Other receivables and accruals	1,069	-	1,772	-
Total	**800,042**	**11,058**	**770,826**	**-**
Other financial assets[184]	-	139,857	-	139,793
Total current and non-current	**950,957**		**910,619**	

	Consolidated group			
	2024/25 Current £000	2024/25 Non-current £000	2023/24 Current £000	2023/24 Non-current £000
NHS receivables: revenue	702,885	-	560,114	-
NHS prepayments	161,240	-	240,275	-
NHS accrued income	72,021	-	74,010	-
NHS non-contract	830	-	859	-
Non-NHS and other WGA receivables: Revenue	675,573	-	852,576	-
Non-NHS and other WGA prepayments	536,302	11,058	362,035	12
Non-NHS and other WGA accrued income	325,299	-	346,895	-
Non-NHS and other WGA non-contract	7,835	-	8,189	-
Expected credit loss allowance-receivables	(86,086)	-	(57,669)	-
VAT	88,610	-	59,415	-
Finance lease receivables	556	-	697	-
Other receivables and accruals	39,475	-	41,549	-
Total	**2,524,540**	**11,058**	**2,488,945**	**12**
Other financial assets[184]	-	1,106	-	1,106
Total current and non-current	**2,536,704**		**2,490,063**	

[184] Other financial assets within Parent relate to the NHS England investment within NHS Supply Chain Co-ordination LTD, which is a component of the Consolidated Group and so removed at Group. The Consolidated Group relates to 1 ICBs investment.

10. Cash and cash equivalents

	Note	Parent		Consolidated group	
		2024/25 £000	2023/24 £000	2024/25 £000	2023/24 £000
Balance at 1 April		286,416	374,885	408,621	584,303
Transfer in from other org under absorption		-	178,170	1,077	178,170
Net change in year		139,170	(266,639)	123,248	(353,852)
Balance at statement of financial position date		**425,586**	**286,416**	**532,946**	**408,621**
Made up of:					
Cash with the Government Banking Service		383,688	272,350	509,958	423,597
Hosted cash/cash in hand		41,898	14,031	41,257	13,466
Current investments		-	35	-	35
Cash and cash equivalents as in statement of financial position		**425,586**	**286,416**	**551,215**	**437,098**
Bank overdraft: Government Banking Service	11	-	-	(18,269)	(28,477)
Total bank overdrafts		**-**	**-**	**(18,269)**	**(28,477)**
Balance at statement of financial position date		**425,586**	**286,416**	**532,946**	**408,621**

For details of bank overdraft see Note 11.

Included within hosted cash/cash in hand above is £41.9 million (2023/24 £14.0 million) held on behalf of NHS England by the NHS Business Services Authority.

Current investments within cash and cash equivalents include cash held in solicitor commercial escrow accounts that is not available for use by the group.

11. Trade and other payables

Parent	2024/25 Current £000	2024/25 Non-current £000	2023/24 Current £000	2023/24 Non-current £000
NHS payables: revenue	84,740	-	119,492	-
NHS payables: capital	18,503	-	26,044	-
NHS accruals	865,400	-	995,745	-
NHS deferred income	1,487	-	1,367	5
NHS contract liabilities	-	-	-	-
Non-NHS and other WGA payables: revenue	195,216	-	209,536	-
Non-NHS and other WGA payables: capital	126,581	-	37,874	-
Non-NHS and other WGA accruals	709,481	-	788,101	-
Non-NHS and other WGA deferred income	3,537	-	2,394	-
Non-NHS contract liabilities	-	-	-	-
Social security costs	17,012	-	17,360	-
VAT	1,103	-	234	-
Tax	19,231	-	31,383	-
Payments received on account	(4)	-	1	-
Other payables and accruals	292,307	-	426,562	11
Total	**2,334,594**	**-**	**2,656,093**	**16**
Other financial liabilities				
Bank overdraft - Government Banking Service	-	-	-	-
Loans from Department of Health and Social Care[185]	-	-	-	-
Total trade & other payables (current)	**-**	**-**	**-**	**-**
Total trade & other payables (non-current)	**2,334,594**		**2,656,093**	
Total trade & other payables (current and non-current)		**-**		**16**

Consolidated group	2024/25 Current £000	2024/25 Non-current £000	2023/24 Current £000	2023/24 Non-current £000
NHS payables: revenue	235,656	-	378,883	-
NHS payables: capital	-	-	365	-
NHS accruals	1,629,211	-	1,841,113	-
NHS deferred income	1,026	-	972	5
NHS contract liabilities	173,406	7,985	153,829	7,256
Non-NHS and other WGA payables: revenue	1,884,538	-	1,753,812	-
Non-NHS and other WGA payables: capital	127,149	-	38,807	-
Non-NHS and other WGA accruals	5,633,948	-	5,731,029	-
Non-NHS and other WGA deferred income	86,197	-	94,933	489
Non-NHS contract liabilities	-	-	46	-
Social security costs	36,266	-	37,371	-
VAT	40,085	-	28,956	-
Tax	42,223	-	52,068	-
Payments received on account	168	-	1	-
Other payables and accruals	950,028	-	1,125,353	11
Total	**10,839,901**	**7,985**	**11,237,538**	**7,761**
Other financial liabilities				
Bank overdraft - Government Banking Service	18,269	-	28,477	-
Loans from Department of Health and Social Care[185]	-	100,000	1,335	106,000
Total	**18,269**	**100,000**	**29,812**	**106,000**
Total trade & other payables (current)	**10,858,170**		**11,267,350**	
Total trade & other payables (non-current)		**107,985**		**113,761**
Total trade & other payables (current and non-current)		**10,966,155**		**11,381,111**

[185] Loans from the Department of Health and Social Care represent amounts issued to SCCL to provide a working capital facility

12. Net gain/(loss) on transfer by absorption

Business combinations within the public sector are accounted for using absorption accounting principles.

2024/25

On 1 April 2024 the DHSC transferred Informatics GPIT responsibility to NHS England. The liabilities related to the transfer are shown in the table below.

On 1 October 2024 Dudley Integrated Health and Care NHS Trust transferred functions to Black Country ICB. The assets and liabilities related to the transfer are shown in the table below.

Parent 2024/25	Department of Health and Social Care £'000
Transfer of payables	(1,485)
Net gain (loss) on transfers by absorption	**(1,485)**

Consolidated group 2024/25	Department of Health and Social Care £'000	Dudley Integrated Health and Care NHS Trust £'000
Transfer of cash and cash equivalents	-	1,077
Transfer of receivables	-	647
Transfer of payables	(1,485)	(1,276)
Transfer of provisions	-	(3)
Net gain (loss) on transfers by absorption	**(1,485)**	**445**

2023/24

On 1 April 2023, the functions of Health Education England transferred to NHS England. The assets and liabilities related to the transfer are shown in the table below.

On 1 October 2023, NHS England transferred responsibility for functions for Health Services Safety Investigation Branch, to Health Services Safety Investigation Body and Care Quality Commission. The assets and liabilities related to the transfer are shown in the table below.

On 1 February 2024, the DHSC transferred some responsibilities for the New Hospital Programme to NHS England in line with transition to the Sponsor-Delivery model of operation. The assets and liabilities related to the transfer are shown in the table below.

Parent	Health Education England £000	New Hospital Programme (DHSC) £000	HSSIB to HSSIB £000	HSSIB to CQC £000
Transfer of property plant and equipment	3,090	-	(7)	(63)
Transfer of Right of Use assets	4,430	-	-	-
Transfer of intangibles	-	14,256	(28)	(118)
Transfer of cash and cash equivalents	178,170	-	-	-
Transfer of receivables	20,255	-	(86)	(114)
Transfer of payables	(294,325)	(17,394)	44	-
Transfer of provisions	(1,752)	-	-	-
Transfer of Right Of Use liabilities	(4,873)	-	-	-
Transfer of PUPOC provision to ICBs	-	-	-	-
Transfer of PUPOC liability to ICBs	-	-	-	-
Net gain (loss) on transfers by absorption	**(95,005)**	**(3,138)**	**(77)**	**(295)**

Consolidated Group	Health Education England £000	New Hospital Programme (DHSC) £000	HSSIB to HSSIB £000	HSSIB to CQC £000
Transfer of property plant and equipment	3,090	-	(7)	(63)
Transfer of Right of Use assets	4,430	-	-	-
Transfer of intangibles	-	14,256	(28)	(118)
Transfer of cash and cash equivalents	178,170	-	-	-
Transfer of receivables	20,255	-	(86)	(114)
Transfer of payables	(294,325)	(17,394)	44	-
Transfer of provisions	(1,752)	-	-	-
Transfer of Right Of Use liabilities	(4,873)	-	-	-
Transfer of PUPOC provision	-	-	-	-
Transfer of PUPOC liability	-	-	-	-
Net (gain) loss on transfers by absorption	**(95,005)**	**(3,138)**	**(77)**	**(295)**

13. Finance costs

	Parent		Consolidated group	
Interest	**2024/25 £000**	**2023/24 £000**	**2024/25 £000**	**2023/24 £000**
Interest on loans and overdrafts	-	-	4,090	3,591
Interest on obligations under finance leases	3,250	1,643	6,071	4,189
Interest on late payment of commercial debt	-	-	4	2
Other interest expense	-	-	1	36
Total interest	**3,250**	**1,643**	**10,166**	**7,818**
Provisions: unwinding of discount	11,373	14,489	11,454	14,484
Total finance costs	**14,623**	**16,132**	**21,620**	**22,302**

14. Provisions

Parent	**2024/25 Current £000**	**2024/25 Non-current £000**	**2023/24 Current £000**	**2023/24 Non-current £000**
Restructuring	-	-	-	-
Redundancy	12,689	-	15,140	-
Legal claims	174	626	48	710
Continuing care	-	-	1,444	-
Clinician tax charge	6,983	218,270	5,504	213,274
Other	50,892	55,950	39,847	93,607
Total	**70,738**	**274,846**	**61,983**	**307,591**
Total current and non-current	**345,584**		**369,574**	

Parent 2024/25	**Restructuring £000**	**Redundancy £000**	**Legal claims £000**	**Continuing care £000**	**Clinician tax charge £000**	**Other £000**	**Total £000**
Balance at 1 April 2024	**-**	**15,140**	**758**	**1,444**	**218,778**	**133,454**	**369,574**
Arising during the year	-	10,584	184	-	4,460	38,713	**53,941**
Utilised during the year	-	(10,289)	(55)	-	(5,038)	(32,083)	**(47,465)**
Reversed unused	-	(2,746)	(87)	(1,444)	(1,874)	(33,740)	**(39,891)**
Unwinding of discount	-	-	-	-	10,983	391	**11,374**
Change in discount rate	-	-	-	-	(2,056)	107	**(1,949)**
Transfer (to)/from other public sector body under absorption	-	-	-	-	-	-	**-**
Balance at 31 March 2025	**-**	**12,689**	**800**	**-**	**225,253**	**106,842**	**345,584**
Expected timing of cash flows:							
Within one year	-	12,689	174	-	6,983	50,892	**70,738**
Between one and five years	-	-	626	-	21,632	34,650	**56,908**
After five years	-	-	-	-	196,638	21,300	**217,938**
Balance at 31 March 2025	**-**	**12,689**	**800**	**-**	**225,253**	**106,842**	**345,584**

Consolidated group	2024/25 Current £000	2024/25 Non-current £000	2023/24 Current £000	2023/24 Non-current £000
Restructuring	1,644	-	4,278	469
Redundancy	21,068	-	64,295	1,803
Legal claims	6,909	3,411	8,968	721
Continuing care	55,484	10,338	53,454	12,852
Clinician tax charge	6,983	218,270	5,504	213,274
Other	103,285	80,895	85,223	119,443
Total	**195,373**	**312,914**	**221,722**	**348,562**
Total current and non-current	**508,287**		**570,284**	

Consolidated group 2024/25	Restructuring £000	Redundancy £000	Legal claims £000	Continuing care £000	Clinician tax charge £000	Other £000	Total £000
Balance at 1 April 2024	**4,747**	**66,098**	**9,689**	**66,306**	**218,778**	**204,666**	**570,284**
Arising during the year	20	13,802	9,235	43,579	4,460	104,197	175,293
Utilised during the year	(1,515)	(40,631)	(1,861)	(18,778)	(5,038)	(45,728)	(113,551)
Reversed unused	(1,608)	(18,214)	(6,743)	(25,309)	(1,874)	(79,442)	(133,190)
Unwinding of discount	-	13	-	31	10,983	428	11,455
Change in discount rate	-	-	-	(7)	(2,056)	56	(2,007)
Transfer (to)/from other public sector body under absorption	-	-	-	-	-	3	3
Balance at 31 March 2025	**1,644**	**21,068**	**10,320**	**65,822**	**225,253**	**184,180**	**508,287**
Expected timing of cash flows:							
Within one year	1,644	21,068	6,909	55,484	6,983	103,285	195,373
Between one and five years	-	-	3,411	10,338	21,632	49,020	84,401
After five years	-	-	-	-	196,638	31,875	228,513
Balance at 31 March 2025	**1,644**	**21,068**	**10,320**	**65,822**	**225,253**	**184,180**	**508,287**

Continuing care' refers to NHS funding for complex packages of care in the community. This includes the following: NHS Continuing Healthcare, where an individual, aged 18 or over, has been assessed as having a 'primary health need' and the NHS has responsibility for arranging and funding a package of health and social care. Children and Young People's Continuing Care, where individuals, up to their 18th birthday, have complex needs arising from disability, accident or illness and require care and support that cannot be met by existing universal or specialist services alone the NHS can fund an additional package of healthcare. Joint packages of health and social care, where an individual's care or support package is funded by both the NHS and the local authority. NHS funded nursing care where funding is provided by the NHS to care homes with nursing, to support the provision of nursing care by a registered nurse. These are set out in the National Framework for NHS Continuing Healthcare and NHS funded nursing care. The amount included in the table above as 'Continuing Care'

represents the best estimate, at the year-end date, of the liabilities of the NHS England group relating to the obligation of the NHS to pay for cases of such care and deliver these services.

The Clinician Tax Charge provision In the parent is £225 million for the commitment to pay clinicians in the NHS Pension Scheme for the effect of the 2019/20 Scheme Pays deduction on their income from the NHS Pension Scheme in retirement, in line with the ministerial direction to the DHSC and NHS England.

Other provisions in both the parent and the group is primarily provisions for pension disputes and dilapidations.

The NHS Resolution financial statements disclose a provision of £46,931,324 as at 31 March 2025 in respect of clinical negligence liabilities and employment liability scheme of NHS England (31 March 2024: £52,797,322).

15. Contingencies

	Parent		Consolidated group	
Contingent liabilities	**2024/25 £000**	**2023/24 £000**	**2024/25 £000**	**2023/24 £000**
Employment tribunal	2,288	1,583	2,335	1,583
NHS Resolution employee liability claim	-	12	1	12
Redundancy	-	-	-	126
Continuing healthcare	-	-	13,858	11,817
GP Non-Reimbursable property costs	-	-	3,092	3,175
Legal claims	1,864	10,226	2,503	10,426
Liverpool Community Health Trust (re Maternity and neonatal investigation)	500	500	500	500
Christies Foundation Trust (re Maternity and neonatal care investigation)	-	300	-	300
Legacy clinician IR35 tax liability	-	-	-	1,812
Joint Procurement Challenges	-	-	550	-
His Majesty's Revenue and Customs	71,362	-	71,362	-
Clinical Negligence Claim	-	-	10	-
Total contingent liabilities	**76,014**	**12,621**	**94,211**	**29,751**

	Parent		Consolidated group	
Contingent assets	**2024/25 £000**	**2023/24 £000**	**2024/25 £000**	**2023/24 £000**
Legal cases	-	495	756	1,320
VAT recovery from His Majesty's Revenue and Customs	-	-	-	1,726
Home Oxygen Rebate	-	-	-	684
Greenacres, Droitwich Road, Hanbury, Redditch	-	-	762	762
Total contingent assets	**-**	**495**	**1,518**	**4,492**

Contingent liabilities are those for which provisions have not been recorded as there is a possible obligation depending on uncertain future events, or a present obligation where payment is not probable, or the amount cannot be measured reliably.

Contingent assets are those where a possible asset arises from a past event and whose existence will be confirmed only by the occurrence or non-occurrence of an uncertain future event not wholly within the control of the entity. These are disclosed only when the inflow of economic benefit is probable.

16. Commitments

16.1 Capital commitments

	Parent		Consolidated group	
	2024/25 £000	2023/24 £000	2024/25 £000	2023/24 £000
Property, plant and equipment	11,825	23,330	11,825	23,330
Intangible assets	300	-	1,520	5,694
Total	**12,125**	**23,330**	**13,345**	**29,024**

16.2 Other financial commitments

NHS England has entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) which expire as follows:

	Parent		Consolidated group	
	2024/25 £000	2023/24 £000	2024/25 £000	2023/24 £000
In not more than 1 year	1,070,225	943, 525	1,426,722	1,201,524
In more than 1 year but not more than 5 years	1,000,862	643,883	1,710,842	731,099
In more than 5 years	26,998	20,857	346,500	51,412
Total	**2,098,085**	**1,608,265**	**3,484,064**	**1,984,035**

In the parent account the most significant contracts relate to:

a) Cloud Service Delivery Partner
b) NHSMail Collaboration Licensing Platform
c) Health and Justice healthcare contracts with PPG
d) Integrated Single Financial Environment contract with NHS SBS

Excluding the largest parent financial commitments already disclosed, the most significant other group commitments relate to:

a) a contract between HCRG Care Services Ltd. and NHS Bath and North East Somerset, Swindon and Wiltshire ICB in relation to Community Services.

17. Financial instruments

17.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS England is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. NHS England has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing NHS England and the ICBs in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS England SFIs and policies agreed by the ICB Governing Bodies. Treasury activity is subject to review by the NHS England internal auditors.

17.1.1 Currency risk

NHS England is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based.

NHS England has no overseas operations. NHS England therefore has low exposure to currency rate fluctuations.

17.1.2 Interest rate risk

NHS England does not have any borrowings that are subject to interest rate risk.

17.1.3 Credit risk

Because the majority of NHS England revenue comes from parliamentary funding, NHS England has low exposure to credit risk. The maximum exposure as at the end of the financial year is in receivables from customers, as disclosed in the trade and other receivables note.

17.1.4 Liquidity risk

NHS England is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament.

NHS England draws down cash to cover expenditure, as the need arises. NHS England is not, therefore, exposed to significant liquidity risks.

17.1.5 Financial instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity, or market risk.

18. Operating segments

Consolidated group 2024/25	ICB £000	SCCL £000	Direct commissioning £000	NHS England £000	Multi-Professional Education and Training Investment Plan £000	Other £000	Intra-group eliminations £000	NHS England group total £000
Income	(2,080,437)	(4,293,837)	(27,292)	(253,344)	(2,075)	(491,870)	736,916	**(6,411,939)**
Gross expenditure	152,974,602	4,293,773	24,321,053	10,318,372	5,321,429	627,206	(736,916)	**197,119,519**
Total net expenditure	**150,894,165**	**(64)**	**24,293,761**	**10,065,028**	**5,319,354**	**135,336**	**-**	**190,707,580**
Revenue resource expenditure								
Revenue departmental expenditure limit								**190,522,217**
Annually managed expenditure								**(28,393)**
Technical expenditure								**213,756**
Net expenditure for the financial year charged to financial performance limits								**190,707,580**

Consolidated group 2023/24	ICB £000	SCCL £000	Direct commissioning £000	NHS England £000	Multi-Professional Education and Training Investment Plan £000	Other £000	Intra-group eliminations £000	NHS England group total £000
Income	(2,159,002)	(3,788,087)	(27,841)	(144,959)	(5,181)	(519,075)	764,703	**(5,879,442)**
Gross expenditure	135,834,128	3,789,756	27,611,951	8,362,083	4,825,864	441,026	(764,703)	**180,100,105**
Total net expenditure	**133,675,126**	**1,669**	**27,584,110**	**8,217,124**	**4,820,683**	**(78,049)**	**-**	**174,220,663**
Revenue resource expenditure								
Revenue departmental expenditure limit								174,110,571
Annually managed expenditure								(80,094)
Technical expenditure								190,186
Net expenditure for the financial year charged to financial performance limits								**174,220,663**

The reportable segments disclosed within this note reflect the current structure of NHS England with the activities of each reportable segment reflecting the remit of the organisation.
These operating segments are regularly reported to the NHS England Board of Directors for financial management and decision-making purposes.

The activities of each segment are defined as follows:-

ICBs - bodies that are responsible for planning most NHS services in their area including commissioning healthcare services, as defined in the Health and Care Act 2022

SCCL - the management function for the NHS Supply Chain operating model

Direct Commissioning - the services commissioned by NHS England as defined in the Health and Social Care Act 2012

NHS England - the central administration of the organisation and centrally managed programmes

Multi-Professional Education and Training Investment Plan - a multi-year view of our future NHS workforce investment. It optimises domestic education and training by balancing professional, geographical, and clinical service demand with education capacity

Other - includes commissioning support units, national reserves, technical accounting items and legacy balances

Multiple transactions take place between reportable segments, all of which are eliminated upon consolidation as shown in the "Intra-group eliminations" column. Information on total assets and liabilities and net assets and liabilities is not separately reported to the Chief Operating Decision Maker and thus, in accordance with IFRS 8, does not form part of this disclosure.

19. Related party transactions

Related party transactions associated with the Parent are disclosed within this note.
As disclosed in note 1.3 NHS England acts as the parent to 42 ICBs whose accounts are consolidated within these Financial Statements. These bodies are regarded as related parties with which the Parent has had various material transactions during the year; those transactions are disclosed in those entities' financial statements.

The following individuals hold director positions within NHS England and during the year NHS England has transacted with other organisations to which the directors are connected. Details of these relationships and transactions are set out below.

Name and Position in NHS England	Related Party	Nature of Relationship	Expenditure with Related Party £000	Income from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Professor Sir Mark Walport - Non-Executive Director	Imperial College Health Partners	Chair	3,487	0	0	0
Professor Sir Simon Wessely - Non-Executive Director	Combat Stress	Vice President	1,000	0	83	0

The DHSC, as the parent of NHS England, is regarded as a related party. During the year NHS England has had a significant number of material transactions with entities for which the Department is regarded as the parent Department.

For example:

- NHS Foundation Trusts
- NHS Trusts
- NHS Resolution
- NHS Business Services Authority
- NHS Property Services
- NHS Shared Business Services (DH Equity Investment)

In addition, NHS England has had a number of significant transactions with other government departments and their agencies including His Majesty's Revenue and Customs, Ministry of Justice and His Majesty's Prison and Probation Service. No related party transactions were noted with key management personnel other than the ones shown above; and the compensation paid to them which can be found in the remuneration report on page 101.

20. Events after the end of the reporting period

There are no adjusting events after the reporting period which will have a material effect on the financial statements of NHS England.

From 1 April 2026, a number of changes to the structure and boundaries of Integrated Care Boards are scheduled to take effect, following decisions outlined in a written ministerial statement laid before Parliament on 9 September 2025. These developments represent a non-adjusting post balance sheet event as they were not in effect at the reporting date and do not impact the financial position or performance of NHS England for the year ended 31 March 2025. However, they may have implications for future operational structures, governance, and financial reporting arrangements. Further details on the changes are available on the NHS England website.

The Accounts were authorised for issue by the Accounting Officer on the date of the Audit Certificate of the Comptroller & Auditor General.

21. Financial performance targets

The Secretary of State for Health and Social Care issues financial directions to NHS England for each financial year. Annex A2 to the document '2024 to 2025 revised financial directions to NHS England' sets out NHS England's total revenue resource limit and total capital resource limit for 2024/25 and certain additional expenditure controls to which NHS England must adhere. These stem from budgetary controls that HM Treasury applies to the DHSC.

	2024/25 RDEL Non ringfenced £000	2024/25 RDEL Ringfenced £000	2024/25 Total RDEL £000	2024/25 Annually managed expenditure £000	2024/25 Technical £000	2024/25 Total £000	2023/24 Total £000
Expenditure limit	190,990,000	393,000	191,383,000	250,000	250,000	**191,883,000**	175,760,000
Actual expenditure	190,193,081	329,136	190,522,217	(28,393)	213,756	**190,707,580**	174,220,663
Surplus	**796,919**	**63,864**	**860,783**	**278,393**	**36,244**	**1,175,420**	1,539,337

	2024/25 Capital departmental expenditure limit £000	2024/25 Capital annually managed expenditure £000	2024/25 Total £000	2023/24 Capital resource limit £000
Annual Limit	626,000	13,000	**639,000**	452,000
Actual expenditure	610,534	429	**610,963**	386,794
Surplus/(Deficit)	**15,466**	**12,571**	**28,037**	**65,206**

NHS England is required to spend no more than £2,161,000k of its Revenue Departmental Expenditure Limit on matters relating to administration. The actual amount spent on RDEL administration matters to 31st March 2025 was £1,768,542k as set out below:

Administration limit:	2024/25 £000	2023/24 £000
Net administration costs before interest	1,760,411	1,926,063
Less:		
Administration expenditure covered by AME/Technical funding	8,131	(34,141)
Administration costs relating to RDEL	1,768,542	1,891,922
RDEL Administration expenditure limit	2,161,000	2,127,000
Underspend	**392,458**	**235,078**

The various limits of expenditure set out in the table above stem from the limits imposed by HM Treasury on the DHSC. Departmental Expenditure Limits are set in the Spending Review, and government departments may not exceed the limits they have been set. This control is passed down to NHS England by the DHSC and NHS England may not therefore exceed its Departmental Expenditure Limit.

Annually Managed Expenditure is subject to budgets set by HM Treasury. Departments must manage AME closely and inform HM Treasury if they expect AME to rise above forecast. Any increase requires HM Treasury approval.

22. Entities within the consolidated group

NHS England acts as the Parent of the group comprising 42 ICBs (2023/24: 42 ICBs) whose accounts are consolidated within these Financial Statements.

A full list of the ICBs can be found on the NHS England website https://www.nhs.uk/nhs-services/find-your-local-integrated-care-board/

NHS England acts as the Parent of SCCL whose accounts are consolidated within these financial statements. Copies of their accounts can be found on their website https://www.supplychain.nhs.uk/sccl/

The parent entity of NHS England is the DHSC.

The largest group of entities for which group accounts are drawn up and of which NHS England is a member is the DHSC Group.

Copies of the accounts can be obtained from the website www.gov.uk/government/publications.

Appendices

Appendix 1: How we delivered against the government's mandate to the NHS

The government's mandate to NHS England sets out high-level priorities and objectives the organisation must seek to achieve. For the financial year 2024/25, NHS England had objectives under two mandates: the first originally set in 2023 by the previous government, and the most recent mandate published on 30 January 2025. This assessment covers both the objectives within the 2023 mandate and those included in the current 2025 mandate, using data between April 2024 to March 2025.

The government's 2023 mandate set out three priorities: to cut NHS waiting lists and recover performance; support the workforce through training, retention and modernising the way staff work; and to deliver recovery using data and technology. The government's 2025 mandate sets out five priorities: reform to cut waiting lists; reform to improve primary care access; reform to improve UEC; reform to the operating model; and reform to drive efficiency and productivity.

In many cases the priorities and objectives overlapped across the two mandates. In these areas, assessment was consolidated against both, and a summary is included below.

Elective Care and Diagnostics

In 2024/25, NHS England made some progress in tackling the persistent issue of long elective care waiting times. From March 2024 to March 2025, the overall waiting list fell from 7.5 million to 7.4 million, with reductions in long waits: 65-week waiters dropped by 85%, and 52-week waiters by 42% compared to March 2024. Additionally, from March 2024 to March 2025, performance against the 18-week standard improved from 57.2% to 59.8%. However, this has not met the standards set out in the NHS Constitution.

The NHS continued to increase theatre capacity in 2024/25. As of April 2025, there are 116 elective surgical hubs operational across England, including 29 which are Targeted Investment Fund funded. 44 surgical hubs have so far been accredited for clinical and operational excellence. We are currently in the process of running cohorts 7/8 with the expectation of accreditation being awarded in April 2025.

Diagnostic wait times also improved, 18.4% of patients on the diagnostic waiting list in March 2025 had still been waiting more than 6 weeks. This compared to 21.9% in March 2024. The rollout of CDCs exceeded the ambition of 160 set out in the Elective Recovery Plan (February 2022), with 169 CDC sites operational by March 2025. CDCs delivered 6.8 million additional tests in 2024/25. These included over 1 million CT scans and 900,000 physiological tests.

Urgent and Emergency Care

Significant pressures in UEC persisted in 2024/25. In 2024/25 capital incentives supported improvements in high-performing A&Es, the 2024/25 Additional Capacity Targeted Investment Fund scheme distributed £150 million of capital to support improvements, and the Rapid Improvement Offer programme supported challenged acute trusts with the longest A&E delays. A&E and ambulance metrics showed modest improvements despite increased demand. The 4-hour A&E performance improved marginally to 75% in 2024/25 (2023/24: 74%). In 2024/25 national category 2 ambulance response times reduced by 1 minute, compared to 2023/24, but remains almost double the 18-minute target at over 35 minutes.

NHS England met its target to add 5,000 extra beds to the permanent bed base to improve capacity and deployed 800 new ambulances. Virtual wards also now provide nearly 13,000 beds. Challenges in delayed discharges were tackled through the Better Care Fund and new discharge metrics.

The 2025/26 UEC Delivery Plan recognises the ongoing challenges in UEC delivery and focuses on improving flow through hospitals, reducing ambulance handover times, and improving patient discharge processes, and is aligned with the 10-Year Health Plan.

Data and technology

By March 2025, 91% of NHS Trusts had implemented an EPR. Over 75% of adult social care providers have a digital care plan and have adopted Digital Social Care Records, covering 85% of CQC registered adult social care recipients.

The NHS FDP enables NHS organisations to bring together operational data. The NHS FDP began roll-out to NHS trusts in April 2024. By March 2025, 108 trusts and 40 ICBs had formally signed up to implement the platform, and 72 trusts and 39 ICBs have been onboarded. Early benefits within the trusts that have adopted FDP products include 70,000 inpatient and 205,000 outpatients wait list removals and an 18% reduction in long-stay discharge delay days.

Usage of the NHS App by patients to manage prescriptions, access records, manage primary and secondary care appointments and communications all significantly increased this year. Compared to March 2024, in March 2025, the number of prescriptions managed through the NHS App totalled 5.5 million, up 49%, the number of records accessed through the NHS App totalled 24.6 million, up 70%, and the number of primary care appointments managed through the NHS App was 415,000 plus 2.4 million online consultation interactions, up 36% and 56% respectively. In secondary care, the number of secondary care appointments managed through the NHS App totalled 4.5 million, up 98%.

Primary care

Primary care continues to face high demand and workforce pressures. Between March 2024 and March 2025, there was a 3.7% increase in GP appointments (including COVID-19 vaccinations). 88.1% of appointments not usually booked in advance, took place within 14 days and 44.2% of all appointments on the same day. 99.9% of the total GP estate now uses digital

telephony and over 98% of practices are using online consultation, appointment booking and messaging systems.

Mental health services

Mental health services access expanded: 655,000 adults, 63,000 perinatal women, and 822,000 children and young people accessed services in 2024/25. Eating disorder referral targets were met for over 73% of cases.

All ICBs have three-year plans for local mental health inpatient redesign in line with an evidence-based Commissioning Framework. 61 providers of NHS-commissioned mental health inpatient services are in receipt of a national culture change improvement programme, the Culture of Care Programme, to support delivery of national standards.

Community-based care

On 30th January 2025, 2025/26, Neighbourhood Health Guidelines were published[186] alongside the 2025/26 NHS Planning Guidance and the 2025/26 Better Care Fund policy framework. These guidelines asked systems to standardise and scale the six core components of Neighbourhood Health in 2025/26, as set out in the guidelines.

Access to community mental health services has improved. In the year to February 2025, 654,679 (February 2024: 599,320) adults accessed community mental health services with two or more care contacts.

Urgent Community Response referrals averaged 154 per 100,000 in 2024/25, with 83% seen within two hours. Self-referrals reached 255,000 in January 2025.

By February 2025 community pharmacy was delivering an increased number of clinical pathway consultations, with the monthly data evidencing performance exceeding Pharmacy First targets for oral contraception consultations and blood pressure checks.

In November 2024, NHS England published Insightful Board guidance[187] for providers and ICBs. ICBs have a unique role in supporting wider primary and community care working to be sustainable, and the Insightful Board documents support that by providing clarity around the critical information boards need to understand their organisations and plan appropriate care for their local population.

[186] https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/
[187] https://www.england.nhs.uk/publication/the-insightful-icb-board/

Cancer services

One-year survival for people diagnosed with cancer in 2020 is 74.6%, and five-year survival for people diagnosed in 2016 is 55.7%. Performance against the Faster Diagnosis Standard (a person should have cancer ruled out or receive a diagnosis within 28 days of an urgent cancer referral) improved from 77.3% in March 2024 to 78.9% in March 2025, exceeding the 75% standard. Performance against the 62-day treatment standard improved from 68.9% to 71.4% between March 2024 and March 2025.

The proportion of cancers diagnosed at stage 1 and 2 rose to 59.1% by February 2025 which is up from 57.6% as of February 2024 and up from 55.9% in February 2020.[188] This equates to an estimated 8,800 more stage 1 and 2 cancer diagnoses in the 12 months to February 2025 compared to pre-pandemic. NHS lung cancer screening continues to roll out, with over 3,000 lung cancers diagnosed in 2024/25, an increase from 2,000 in 2023/24. 75% of cancers diagnosed through the programme are caught at an early stage, compared to 29% outside of the programme.

The following objective was only included in the 2023 mandate:

Workforce growth and retention

In 2024/25, 7,830 medical school places were offered, with an increase to 8,180 planned for 2025/26.[189] Nursing and midwifery course applications rose by 6% compared to pre-pandemic levels. Over 500 pharmacy technicians were trained through a new apprenticeship. Amendments to regulations in June 2024 enabled dental hygienists and therapists to administer and supply specified medicines.

The following objectives were only included in the 2025 mandate:

Reform to the operating model

The 2025 mandate includes an additional objective to reform the NHS operating model.[190] Since February 2025, NHS England has replaced the Oversight and Assessment Framework with the National Oversight Framework (previously the NHS Performance Assessment Framework)[191], which segments organisations from one to five based on metrics and benchmarks. Segment scores influence intervention levels and capital freedoms. Specific proposals for capital freedoms were published in the 2025/26 capital planning guidance.[192]

The Very Senior Managers Pay Framework[193] was revised to provider a stronger link between pay and operational performance by rewarding those who successfully improve performance and penalising those who are persistently failing.

[188] 12-month rolling average https://nhsd-ndrs.shinyapps.io/rcrd/
[189] https://www.officeforstudents.org.uk/for-providers/finance-and-funding/health-education-funding/medical-and-dental-maximum-fundable-limits/
[190] https://www.england.nhs.uk/long-read/our-new-operating-model-supporting-you-to-deliver-high-quality-care-for-patients/
[191] https://www.england.nhs.uk/wp-content/uploads/2025/03/6-the-nhs-performance-assessment-framework-annex.pdf
[192] https://www.england.nhs.uk/long-read/capital-guidance-2025-26/
[193] https://www.england.nhs.uk/leaders/vsm-pay-framework/

Reform to drive efficiency and productivity

In 2024/25 NHS England worked with the DHSC and systems to improve productivity, efficiency and strengthen financial discipline. NHS England refreshed its oversight system to reflect lessons learned from 2023/24 including a revised risk-reporting system for ICBs and providers. NHS England also worked with systems to plan ahead of the year, manage down expenditure and deliver in year efficiencies, including through the targeted Investigation and Intervention programme and strengthening financial controls in quarter 4 2024/25. Whilst significant efficiencies, other cost savings and underspends were delivered across NHS England, ICBs and many NHS providers, these did not entirely offset overspends elsewhere in the NHS providers' sector. This meant that across the NHS budget, NHS England delivered Non-Ringfenced Resource Departmental Expenditure Limit overspend equivalent to less than 0.05% of NHS England's budget, which the DHSC agreed to absorb within the wider group budget to ensure that once again the DHSC was able to manage spending within Parliamentary approved limits.

NHS England is now working closely with the DHSC on a finance reset in 2025/26, to strengthen financial controls and discipline across NHS systems, building on the new intervention regime, analysis of spend in the most financially challenged systems and a strengthened approach to ensure systems' plans for 2025/26 are balanced.

Appendix 2: Meeting our Public Sector Equality Duty

In May 2024, NHS England's Board approved and published NHS England's equality objectives and targets for 2024/25 and for 2025/26. Progress was reviewed during 2024/25 and in May 2025, and NHS England's Board considered a paper[194] recommending approval and publication of a review report for 2024/25.[195] The Board also approved updated equality objectives and targets for 2025/26.[196]

In developing our equality objectives and targets, we are required to focus on the Equality Act (2010)'s nine protected characteristics[197] where there is evidence of a need to take strategic action to address discrimination or other matters that are unlawful, advance equality of opportunity, or foster good relations.

The 2024/25 review report demonstrates how NHS England continued to meet our statutory requirements under the Equality Act 2010's Public Sector Equality Duty[198] and the associated Specific Equality Duties[199] (SEDs). Central to these statutory requirements is the duty to publish equality information annually. The full 2024/25 review report is available on NHS England's website[200] and provides a range of key equality information as of 31 March 2025, as required by the SEDs, including:

- planned changes to employment and equality legislation coming into force later in 2025/26 or 2026/27[201]
- an explanation of the changing context which will affect NHS England in the next year as the organisation will cease to exist as a separate legal entity and will integrate to the DHSC[202]
- four recommendations on what may be done in 2025/26 to balance the impact of these changes to the SEDs[203]
- a summary assessment of performance against our eight equality objectives and associated 2024/25 targets[204], along with further information[205] on work undertaken by NHS England during the reporting period.

[194] https://www.england.nhs.uk/long-read/specific-equality-duties-review-report-as-at-29-may-2025/
[195] https://www.england.nhs.uk/long-read/review-of-progress-in-2024-25-delivering-the-equality-objectives-and-meeting-the-wider-equality-requirements/
[196] https://www.england.nhs.uk/about/equality/objectives-24-25-and-25-26/
[197] https://www.equalityhumanrights.com/equality/equality-act-2010/protected-characteristics
[198] https://www.legislation.gov.uk/ukpga/2010/15/section/149
[199] https://www.legislation.gov.uk/uksi/2017/353/contents
[200] https://www.england.nhs.uk/long-read/review-of-progress-in-2024-25-delivering-the-equality-objectives-and-meeting-the-wider-equality-requirements/
[201] https://www.england.nhs.uk/long-read/review-of-progress-in-2024-25-delivering-the-equality-objectives-and-meeting-the-wider-equality-requirements/#5-major-legislative-and-nhs-reforms-and-the-impact-on-nhs-england-s-equality-objectives-and-targets:~:text=5.1%20Recent%20and%20planned%20changes%20to%20Equality%20legislation
[202] https://www.england.nhs.uk/long-read/review-of-progress-in-2024-25-delivering-the-equality-objectives-and-meeting-the-wider-equality-requirements/#5-major-legislative-and-nhs-reforms-and-the-impact-on-nhs-england-s-equality-objectives-and-targets:~:text=5.1%20Recent%20and%20planned%20changes%20to%20Equality%20legislation
[203] https://www.england.nhs.uk/long-read/review-of-progress-in-2024-25-delivering-the-equality-objectives-and-meeting-the-wider-equality-requirements/#5-major-legislative-and-nhs-reforms-and-the-impact-on-nhs-england-s-equality-objectives-and-targets:~:text=5.3%20Recommendations%3A%20equality%20objectives%20and%20targets%20for%202025/26
[204] https://www.england.nhs.uk/long-read/review-of-progress-in-2024-25-delivering-the-equality-objectives-and-meeting-the-wider-equality-requirements/#3-progress-against-the-2024-25-equality-objectives-and-targets
[205] https://www.england.nhs.uk/long-read/review-of-progress-in-2024-25-delivering-the-equality-objectives-and-meeting-the-wider-equality-requirements/#4-meeting-our-public-sector-equality-duty-psed-our-wider-equality-information

Appendix 3: Reducing health inequalities

During 2024/25, NHS England continued to discharge its statutory, governance and delivery support responsibilities for health inequalities.

Our strategic approach to reducing healthcare inequalities

Our work across 2024/25 supported ICSs and NHS providers to take further action on the five priority areas for tackling healthcare inequalities:

Restore NHS services inclusively

Following the publication of the Delivery Plan for Recovering UEC Services[206], we now have 83% coverage of High Intensity Use services across Type 1 Emergency Departments (EDs) across England, reflecting the commitment we set out in the UEC Recovery Plan.

We facilitated the implementation of the 'Framework for NHS action on Inclusion Health', promoting improved healthcare access and experiences for socially excluded groups. The framework was referenced in the 2024/25 NHS England Priorities and Planning Guidance, supporting implementation by ICBs. To support this, we developed an ICB action learning network to identify and share common success factors.

We established a Coastal Navigators Network and Accelerator programme in collaboration with Suffolk and North East Essex ICB and Breaking Barriers. Six accelerator sites co-developed transformation projects linked to their coastal locations, with interim learning published in December.[207]

We are developing a Community Languages and Translation Framework for action.

Mitigate against digital exclusion

We have held regular learning and support sessions to embed use of 2024's Inclusive Digital Healthcare: A Framework for NHS action on digital inclusion.[208]

Ensure datasets are complete and timely

Metrics for measuring progress in reducing healthcare inequalities across all the Core20PLUS5 clinical programmes for adults have been agreed and will be available to track using the NHS England Performance Oversight Dashboard. Work to develop healthcare inequalities metrics across the Core20PLUS5 areas for children and young people, and further metrics for adults (including UEC and electives) has begun.

We have developed proposals for improving the quality of ethnicity data and intend to refine and publish these in next financial year.

[206] https://www.england.nhs.uk/long-read/delivery-plan-for-recovering-urgent-and-emergency-care-services-january-2023/
[207] https://bbi.uk.com/coastalnavigtorsnetwork/
[208] https://www.england.nhs.uk/long-read/inclusive-digital-healthcare-a-framework-for-nhs-action-on-digital-inclusion/

Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes

We have produced a Core20PLUS5 Handbook (which brings together best evidence and practice examples to support successful delivery of Core20PLUS5 interventions for underserved groups) for imminent circulation.

To improve quality of care and experience for Sickle Cell Disorder (SCD) and thalassaemia, seven Emergency Department Bypass Units have opened in high-prevalence areas, providing faster pain relief for patients presenting in crisis. Two community development pilots in Manchester and London will offer community nursing and post-discharge follow ups to support these. Investment has been made to improve provision and access to digital care plans for Patients with SCD, supporting healthcare professionals to rapidly access patients' personalised care plans.

A blood group genotyping programme has been introduced, enabling detection of previously undetectable antibodies that could cause blood transfusion complications. Following the NICE's approval of a gene therapy (Exa-cel), the NHS has confirmed funding to offer it to those with the most severe forms of SCD and Major Thalassemia.

In response to the Infected Blood Inquiry, we enhanced our Patient Participation Group to include the UK Thalassaemia Society and the Sickle Cell Society.

Strengthen leadership and accountability

We have worked with stakeholders to develop a health inequalities strategic framework to guide action on healthcare inequalities across the NHS and intend to publish this in sequence with the 10-Year Health Plan.

We have catalysed health inequalities research investment of circa £800 million from organisations including National Institute for Health Research.

We mobilised phase two of the ICB NEDs and Chairs' Health Inequalities leadership programme with representation from 21 ICBs.

In collaboration with the NHS Confederation, we implemented a development offer for primary care health inequalities leads, including webinars to support local implementation of the Core20PLUS5 approach.

We have developed further resources to support Making Every Contact Count and health literacy, including national webinars and a Making Every Contact Count 'How to guide' for acute settings.

In collaboration with Healthcare Finance Management Association, we also developed resources to support finance leads to tackle health inequalities and have recruited Health Inequalities Finance Fellows.

We supported NHS Providers to developing a Board Guide to Health Inequalities.[209]

We worked with the Association of British Pharmaceutical Industries to redevelop their training curriculum and professional exams to incorporate modules on health inequalities.

In partnership with the Royal Society of Medicine, we hosted the third Annual Tackling Health Inequalities Conference with poster presentations and Awards.

Framework for action – Core20PLUS5 approach

Core20PLUS5[210] remains our national and system-level approach to help reduce healthcare inequalities. This year we successfully launched a third cohort of 670 Core20PLUS Ambassadors working across the health system and an accompanying alumni programme.

Our Core20PLUS Connectors programme supports peer-led approaches to address health inequalities. This has involved work with 120 voluntary, community, faith, and social enterprise delivery partner organisations, and local Healthwatch partners.

Finally, we have continued to support the work of NHS Race and Health Observatory and through an open market procurement secured future hosting of NHS Race and Health Observatory until 31/3/2027.

[209] Reducing health inequalities: A guide for NHS trust board members
[210] https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

Appendix 4: Working in partnership with people and communities

In 2024/25, we continued to build NHS England's approach to involving people and communities in our work.

The participation review undertaken in 2023/24 set the foundation for taking forward the good practice embedded in the three legacy organisations (Health Education England, NHS England and NHS Digital) on working in partnership with people and communities.

During 2024/25, we developed a new policy on working with people and communities to cover the new organisation, with the aims of:

- Setting out various approaches to involving people and communities, including online consultation, events, workshops, and the recruitment of PPV Partners
- Supporting colleagues to better understand our legal duty to involve the public (section 13Q of the NHS Act 2006 (as amended)).

The policy was approved by NHS England's Strategy, Investment and Performance Committee and then at NHS England's Quality Committee.

To discharge its legal duty to involve the public, NHS England has an assurance process in place for its commissioning decisions that affect the recipients of NHS services, including their carers and representatives. National and regional reporting on public involvement provides assurance that NHS England has met its legal duty.

We ran engagement sessions for the 10-Year Health Plan to support the inclusion of specific communities covered by our networks and forums. These included the Older People Sounding Board, LGBTI+ Sounding Board, Learning Disability and Autism Advisory Group, and the NHS Citizen Advisory Group.

Examples of how we involve people in our work

Peer Leadership

This year, NHS England's Voices of People Team, in the Primary Care and Community Services directorate, continued to deliver the four Step Peer Leadership Development Programme, empowering over 6,000 people with lived experience to interact with the health and care system and have better conversations with clinicians. This year 350 people worked collaboratively with the health and care system in their local health economies and national programmes, including members of the Strategic Co-Production Group.
Other activities include:

- Publication of commissioning principles for abortion which were developed by Strategic Co-Production Group members
- Development of personas to support use of digital technology for New Hospital Programme
- Supported publication of Universal Offer for Community Services.

Research and health inequalities

At NHS England, research is an important driver of improvement in health and care and in addressing health inequalities, so it is important that our diverse communities are involved in research. In 2024/25 NHS England and the DHSC funded the ICS Research Engagement Network programme. Research Engagement Network teams aim to increase diversity in research participation by engaging with people in underserved communities around research, making research more accessible, and by embedding approaches to diverse research inclusion in how local organisations work.

Data deliberation

The Joint Digital Policy Unit (comprised of NHS England and the DHSC teams) delivered a £1.5 million programme of national public engagement on data in 2024/25. This programme comprised of three cohorts, each covering a different topic within the health and care data landscape. This included the use of data for research, a single patient record and the use of data in the GP health record for planning and research, and the opt out landscape. Each cohort includes a core deliberation, bringing together 120 people across four locations around the country. This is supported by a programme of inclusive engagement with seldom heard voices, as well as a quantitative survey. The programme has reached around 8,600 people so far and fed into the evidence base for the 10-Year Health Plan.

Cancer programme engagement

The National Cancer Programme (NCP) continues to engage with People and Communities through the PPV Forum, spanning the wide range of transformation initiatives, including Early Diagnosis, Faster Diagnosis, Innovation, Living with & Beyond Cancer, Treatment, and Experience of Care. A particular emphasis has been placed on ensuring a diversity of voices in engagement, alongside a targeted focus on reducing health inequalities. The PPV Forum was a key route of engagement in developing the National Cancer Plan, created collaboratively between NHS England and the DHSC, providing scrutiny and challenge. The National Cancer Programme supported engagement by Cancer Alliances by including requirements for engagement through the Cancer Alliance Annual Planning Pack and fostering collaboration among leads within a high-functioning Community of Practice.

Maternity and service user voice

The Maternity and Neonatal Programme works with 21 PPV Partners on its board, committees and all steering groups. This helps ensure that women, babies and families are central to any policies developed. In addition, NHS England has seven regional PPV Partners who contribute service user voice to the regional boards and co-ordinate the Maternity and Neonatal Voices Partnerships (MNVPs) across England. Maternity and Neonatal Voices Partnerships support ICBs and provider trusts to listen to the experiences of women and families, and bring together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care. This influences improvements in the safety, quality, and experience of maternity and neonatal care.

Maximising the impact of NHS volunteers and the VCSE sector

Work has continued to develop volunteering based on the recommendations from the NHS Volunteering Taskforce 2023. Over the past year this has included:

- Continued development of a recruitment website[211] to facilitate an easier route for potential volunteers to find an opportunity that suits their needs. Previously in a testing phase, this platform is now being made more widely available as a single front door for NHS volunteer recruitment.
- £10 million awarded to 15 system level partnerships across England (through the Volunteering for Health programme, in partnership with NHS Charities Together and CW+) and that will use this to develop and deliver volunteer projects in their local ICS. The 15 projects are diverse, innovative and, above all, have a clear ambition to grow and strengthen volunteering in health systems so that everyone gets better healthcare.
- Culmination of the two-year funded Volunteer to Career programme[212], in partnership with Helpforce, supporting routes into careers, particularly clinical workforce pathways which saw 72% of participating volunteers go on to further education, training or employment.
- The NHS and Care Volunteer Responders programme has continued to provide support through micro volunteering opportunities over the past year, with 48,000 volunteers together supporting the delivery of over 100,000 tasks. This has included support through vaccination stewards, telephone companionship and transport tasks amongst other roles.
- In April 2024, the first national data collection for volunteers supporting NHS Trusts was launched, providing consistent and appropriate measures to track the number of NHS volunteers. This shows there are over 71,000 volunteers across NHS Trusts in England, collectively providing over six million hours of volunteering support.
- Maintained support for ambulance trusts through an extension to the National Ambulance Auxiliary service[213] with over 16,500 hours of additional capacity provided, including 881 hours of support to four acute hospitals to release ambulances back on to the road.

Work has also continued to support embedding of VCSE engagement within ICSs with dedicated Communities of Practice and Expert Networks in place for ICB and VCSE Alliance leads. Tools and resources have been co designed with these groups including the Embedding the VCSE in ICS Quality Development tool and RSM Impact Framework.

Working in partnership with carers

Work has continued on our commitment to support young carers, in recognition that young carers are more likely to have poorer health and educational outcomes. We hosted the inaugural cross-departmental Young Carers Data Summit, triangulating intelligence from the Departments of Education, Work and Pensions, and Health and Social Care along with key VCSE organisations, to inform collaborative improvements and enhance partnership working. We published a series of co-produced GP Top Tips to support identification of, and engagement with, young carers within Primary Care.

We continue to work closely with people and communities, leading widescale stakeholder engagement to inform the refresh of key national publications, including commissioning principles and GP Quality Markers. We hosted national roundtables aligned to shifts in the Darzi

[211] https://volunteering.england.nhs.uk
[212] https://helpforce.community/back-to-health/volunteer-to-career-programme
[213] https://www.sja.org.uk/press-centre/press-releases/st-john-commissioned-as-the-nations-ambulance-auxiliary/

report, 'Technology' and ‘Care from Hospital to Community', to promote the carer voice throughout the development of the Long-Term Plan and engaged with Carer entrepreneurs across both shift conversations.

The Health and Wellbeing Alliance Carers Partnership published a new resource for health and social care professionals to improve the identification and support of unpaid carers across ICSs. We continue to provide opportunities to scale and spread learning via well-established national networks and awareness campaigns, including the regional development of hospital discharge toolkits, digital products for contingency planning and supporting carers through virtual wards.

Networks and forums

Across the organisation, we run a wide range of forums, advisory groups and sounding boards, involving people from different communities and health interests. These include the NHS Youth Forum, the Older People’s Sounding Board, the LGBTI+ Sounding Board and the Adult Mental Health Advisory Network.

Many of NHS England’s forums come together as part of the NHS Citizen Advisory Group, which helps to join-up voices from across different programme areas, speaking directly to programme and policy leads. The Advisory Group champions appropriate, effective, and meaningful engagement, including identifying good practice and opportunities for improvement. A couple of example forums that are members are included below:

- NHS England’s Older People’s Sounding Board: Working in partnership with National Development Team for Inclusion, a diverse group of 25 older people have continued to engage with policy makers and clinicians to influence decision making and suggest improvements. They have influence across and beyond NHS England’s directorates; and over the last 12 months they have explored ‘living with frailty’; neighbourhood health and care; hospital discharge to care home; day-case hip, knee and orthopaedic trauma pathways; care partners; integrated care; and NHS building and estates. More recently, they have also contributed the views of older people into the ‘Change NHS’ 10-year planning and have met with the NHS RHO to consider health inequity at the intersection of age and race.
- The Learning Disability and Autism Advisory Group said goodbye and thank you to long standing members and recruited and welcomed 20 new autistic people, people with a learning disability and family carers. They include people of all ages, from different walks of life with diverse ethnicities, backgrounds and experience.

Topics during 2024/25 included co-producing ideas to:

- better meet the needs of people with disabilities when designing hospital buildings
- improve the NHS as part of the Change NHS programme
- highlight the key points to consider when launching the Reasonable Adjustment Digital Flag to people with disabilities
- better develop an autism pathway
- explore what would help people be able to live happier lives in their community, without having to have high numbers of staff surrounding them.

As well as holding meetings, different members also worked on key programmes of work across the year, helping to shape and design policy and guidance. Through the Forum, which has more

than 10,000 members, we shared key national campaign information in more accessible language to widen reach, help raise awareness, explain complex messages and help improve services. We used social media and monthly update email bulletins, along with easy read and plain English versions of a co-produced newsletter.[214]

[214] https://www.england.nhs.uk/learning-disabilities/about/get-involved/newsletters/

Appendix 5: Sustainability

With the conclusion of the 2021-2025 Greening Government Commitments (GGCs), we are pleased to report overall positive progress against the targets.

A: Mitigating climate change: working towards net zero	Target	Actual
Reduce overall GHGs	-44%	-80%
Reduce direct GHGs	-20%	-83%
Reduce emissions from domestic business flights	-30%	-88%
B: Minimising waste and resource efficiency		
Reduce the overall amount of waste generated	-15%	-92%
Reduce the proportion of waste going to landfill	5%	1%
Increase the proportion of waste being recycled	70%	65%
Remove all items of consumer single use plastics (CSUPs)	-100%	245%
Reduce paper use	-50%	96%
C: Reducing water use		
Reduce water consumption	-8%	-87%

Our direct GHGs have reduced by 79% from the 2017/18 baseline year. This can largely be attributed to the size of the reportable estate more than halving, resulting in emissions from gas and electricity use reducing by 84% each. The overall volume of waste has reduced by 92% since 2017/18, against a target to achieve a 15% reduction. Emissions from domestic business flights have reduced by 88% and have reduced significantly since our Flight Approval Panel was established in May 2024.

We have not had success across the board: our overall rate of recycling did not meet the 70% target, and we did not remove Consumer Single Use Plastics (CSUPs) from our estate. We continue to work with landlords, who manage facilities management services on our behalf, to improve waste management. This includes the implementation of the government's Simpler Recycling policy, which came into effect in March 2025. The number of items of CSUPs increased with higher office utilisation after the COVID-19 pandemic. We remain committed to implementing the changes which have been agreed with our supplier to significantly reduce the number of CSUPs items purchased across our estate.

Taskforce on Climate-Related Financial Disclosures

We recognise climate change as a risk to NHS England and to delivery of services across the NHS system. For our own operations, we are dedicated to enhancing environmental impacts from government estates and operations as part of the GGCs, while promoting efficiency and optimal use of taxpayer money. We recognise climate change risks for the wider NHS through our Greener NHS programme and are committed to achieving a net zero NHS by 2040. This involves improving healthcare, reducing harmful carbon emissions, and investing in initiatives that remove GHGs from the atmosphere, acknowledging the inextricable link between climate change and human health.

Governance

Our progress against the GGCs continued to be measured and regularly reported to the Executive Corporate Group (ECG) throughout the year. Where necessary, progress can be reported to the Board via the Executive Group.

Risk Management

NHS England's Risk Management Framework sets out the architecture within which risk management operates in NHS England. The Board and NHS England Executive own the SRR and ORR. Executive and Board committees receive strategic risks and top operational risks that fall under their remit. They assess and challenge the effectiveness of risk mitigation plans and ensure relevant actions are implemented. No risks concerning climate change and NHS England have been recorded on either the SRR or ORR during 2024/25.

Metrics and targets[215]

We are aligned to the targets set out in the GGCs. Our progress against the targets is published annually in this report.

Scope

All reporting in this section covers NHS England and the CSUs. Each trust and ICS have its own Green Plan and will report its sustainability performance separately.

Reporting for multi-occupancy sites

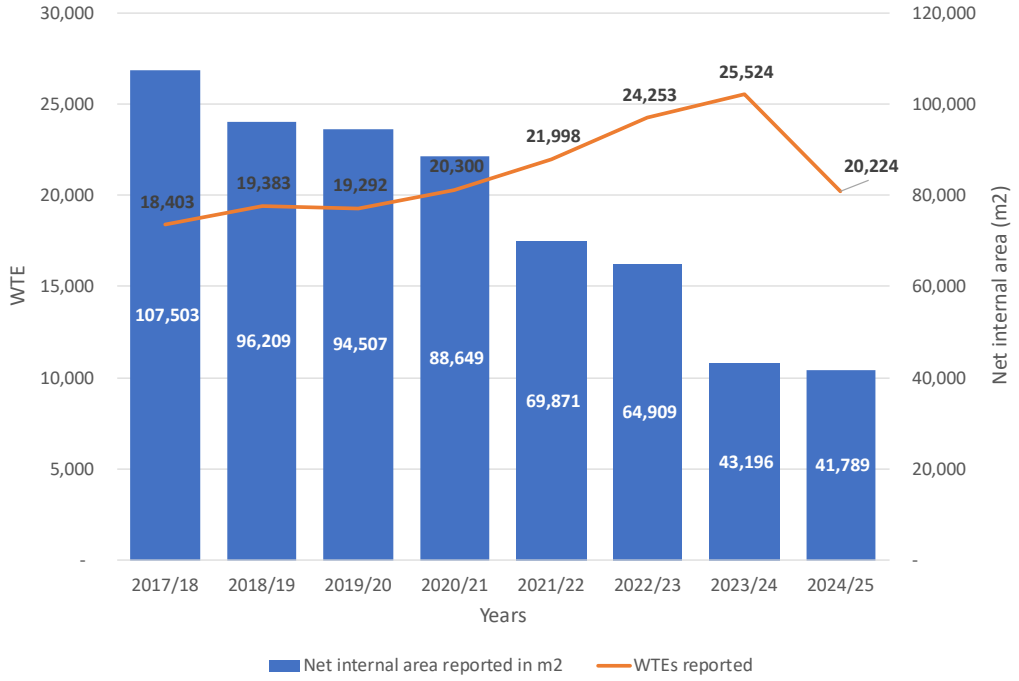
Where we are tenants of a government department, energy, waste, and water information for the whole building will be reported in their annual reports and published on their websites. For all other sites, we report on the proportion of the sites that we occupy. Approximately 43% of our estate is included in this reporting.

Provision of data

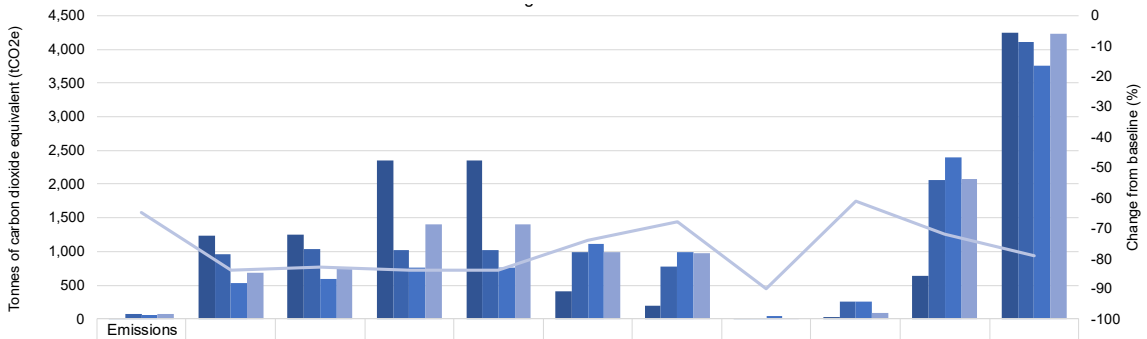
Where actual figures for energy, water and waste were unavailable owing to a lack of data from suppliers and landlords, we have made our best efforts to estimate using available data. Estimates are based on averages per m^2 of Net Internal Area.

[215] Unless otherwise stated, the baseline year is 2017/18

Contextual information



Greenhouse gas emissions[216]



	Emissions from organisation - owned fleet vehicles (tCO2e)	Gas (tCO2e)	Total Scope 1 (tCO2e)	Electricity	Total Scope 2 (tCO2e)	Road travel	Rail Travel	Domestic air travel	International air travel	Total Scope 3 (tCO2e)	Total (tCO2e)
2021/22	16	1235	1251	2,348	2,348	414	194	4	33	645	4,244
2022/23	67	968	1035	1,020	1,020	996	780	19	260	2,055	4,110
2023/24	57	534	591	767	767	1,110	985	42	261	2,399	3,757
2024/25	77	681	758	1,403	1,403	988	977	17	89	2,071	4,232
Change from baseline (%)	-65	-84	-83	-84	-84	-74	-68	-90	-61	-72	-79

[216] Figures marked with * have been restated

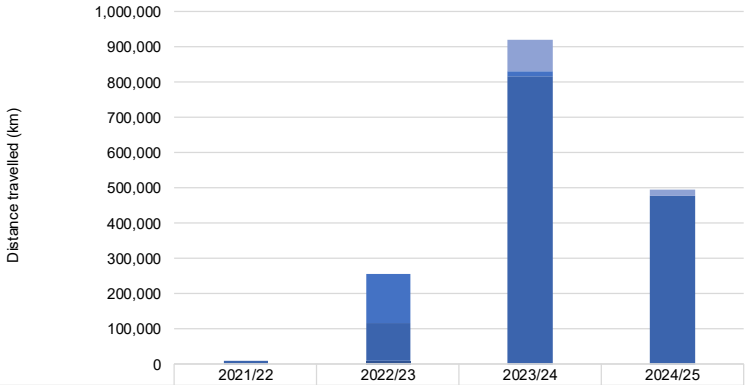
Related use and cost[217]

			2021/22	2022/23	2023/24	2024/25	Change from baseline
Scope 1[218]	Km	Scope 1 business travel	99,511	414,563	699,852*	779,279	-66%
	kWh	Gas	6,740,320	5,302,724	2,926,969*	3,721,038	-83%
	Cost	Scope 1 business travel	£28,565	£145,519	£217,832	£181,429	-51%
		Gas	£298,604	£240,222	£310,546	£284,342	64%
Scope 2[219]	kWh	Electricity	11,060,753	5,273,549	3,718,599*	6,774,884	-72%
	Cost	Electricity	£1,355,197	£824,398	£1,214,235	£1,112,591	-57%
Scope 3 Related use	Km	Road travel	2,475,394	6,192,563	6,990,748*	6,416,785	-81%
		Rail Travel	5,691,051*	30,917,856*	27,755,605*	26,804,110	-57%
		Domestic air travel	30,521*	150,354*	261,643	103,502	-91%
		International air travel	428,159*	911,144*	1,184,953	595,477	-74%
	Total business miles km (scope 1 and 3)		8,724,637*	30,503,294*	36,891,801*	34,699,153	-66%
Scope 3[220] Cost		Road travel	£789,775	£1,881,592	£2,287,977	£1,992,559	-67%
		Rail Travel	£1,472,414	£6,018,908*	£8,551,756	£7,748,290	-53%
	Domestic air travel		£4,807*	£32,962*	£63,459	£26,083	-89%
		International air travel	£3,164*	£37,258*	£116,600	£46,152	-80%
	Total cost of business travel (scope 1& 3)		**£2,298,725***	**£8,116,240***	**£11,237,624***	**£9,994,513**	**-57%**
	Total cost of related use (all scopes)		**£4,239,738**	**£10,417,501**	**£12,762,405**	**£11,391,446**	**-57%**

[217]Figures marked as* have been restated due to more accurate and/or up-to-date figures being available.
[218] Direct emissions – These occur from sources owned or controlled by the organisation.
[219] Energy indirect emissions – As a result of electricity consumed which is supplied by another party.
[220] Other indirect emissions – All other emissions which occur as a consequence of activity in an organisation's value chain, but which are not owned or controlled by the accounting entity.

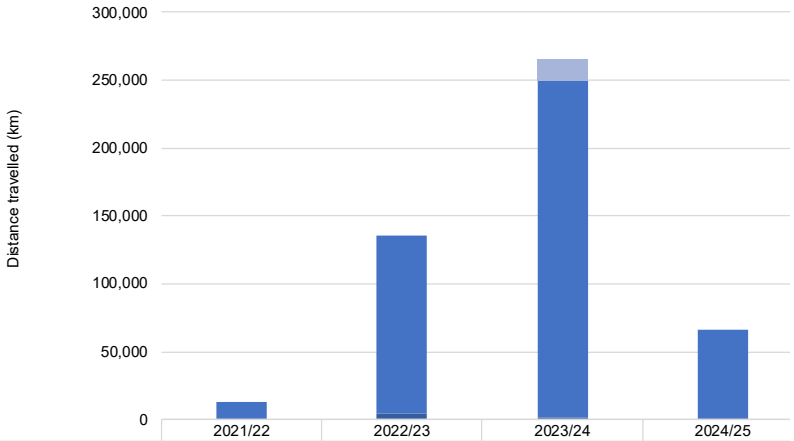
International air travel[221]

Long haul international flights



	2021/22	2022/23	2023/24	2024/25
Long Haul International First	0	0	0	0
Long Haul International Business	0	0	87,551	19,759
Long Haul International Premium Economy	0	139,615	16,792	0
Long Haul International Economy	10,535	106,345	815,327	477,390
Long Haul International Average	0	11,210	0	0

Short haul international flights



	2021/22	2022/23	2023/24	2024/25
Short Haul International Business	0	0	16,274	0
Short Haul International Economy	13,402	130,877	247,336	66,532
Short Haul International Unknown	0	4,218	1,674	0

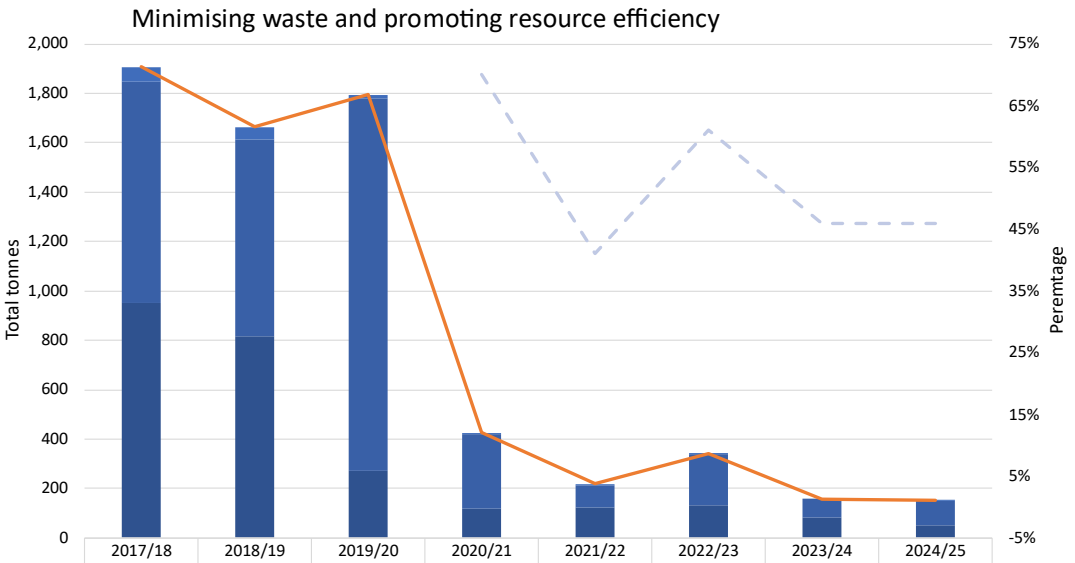
Non-UK international flights[222]

	2021/22	2022/23	2023/24	2024/25
International (non-UK) First				3,634
International (non-UK) Business				0
International (non-UK) Premium Economy				0
International (non-UK) Economy				25,124
International (non-UK) Unknown				3,037

[221] International (non-UK) flights were included in the short haul and long haul international figures in previous years.
[222] These are flights that start and end overseas (i.e. neither departing nor arriving in the UK).

Waste

We have reduced the overall amount of waste generated by 92% since 2017/18, against a target of 15%. Our recycling rate was 65%, against a target of 70%.



	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Incinerated without heat recovery	-	-	-	-	-	-	-	-
Landfill	58	52	15	7	4	1	-	2
Recycled	898	798	1,510	298	90	210	76	99
Incinerated with heat recovery	950	814	270	121	125	131	83	52
Total (tonnes)	1,906	1,664	1,795	425	219	342	159	153
Recycling rate				70%	41%	61%	46%	46%

Cost of waste disposal

	2021/22	2022/23	2023/24	2024/25
Incinerated with heat recovery	£83,931	£83,808	£14,469	£6,252
Cost of recycling	£44,680	£100,952	£14,274	£17,996
Total	**£128,611**	**£184,761**	**£28,743**	**£24,248**

NHS England ICT and digital waste disposal[223]

Waste disposal (tonnes)	2024/25
Donating items within Government	-
Donating items to charity, schools or other NGO	-
Selling items - for commercial sale	81
Recycling (hazardous and non-hazardous)	145
Combustion / Energy recovery	-
Incineration without energy recovery	-
Landfill	-
Total	**226**

We continue to maintain the use of ICT equipment for as long as possible, extending the life of user devices compared to previous years.

When items do become obsolete, we work with other organisations to process our ICT waste responsibly and sustainably. This may be through offering equipment to other public sector organisations that can still make use of them, approved authorised treatment facilities, following waste electrical and electronic equipment regulations or using corporate recycling schemes.

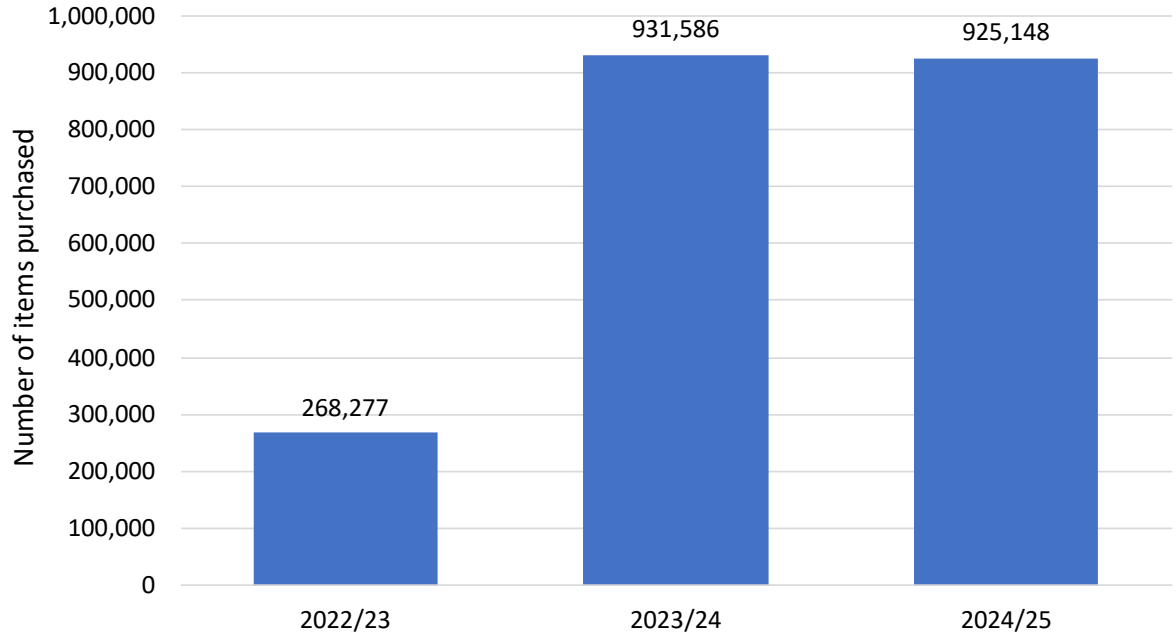
[223] This is the first year we have figures available. Midlands and Lancashire CSU did not submit a return.

We have moved away from hosting our services on our own premises and we now use Crown Hosting (in mission-critical data centres providing leading environmental performance) and cloud hosting.

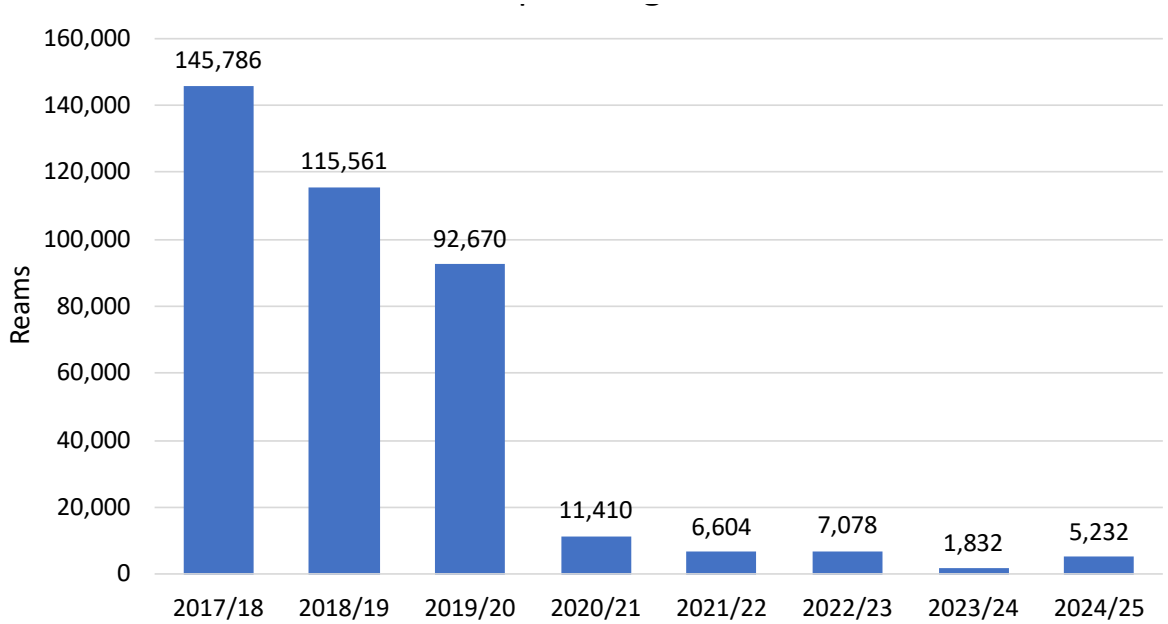
Reuse schemes

Surplus furniture is often reused across the public sector through the Cabinet Office reuse scheme or is donated to other public and charitable organisations locally. The surplus furniture from three office closures this year were donated to a school charity and to other public organisations through the Cabinet Office reuse scheme.

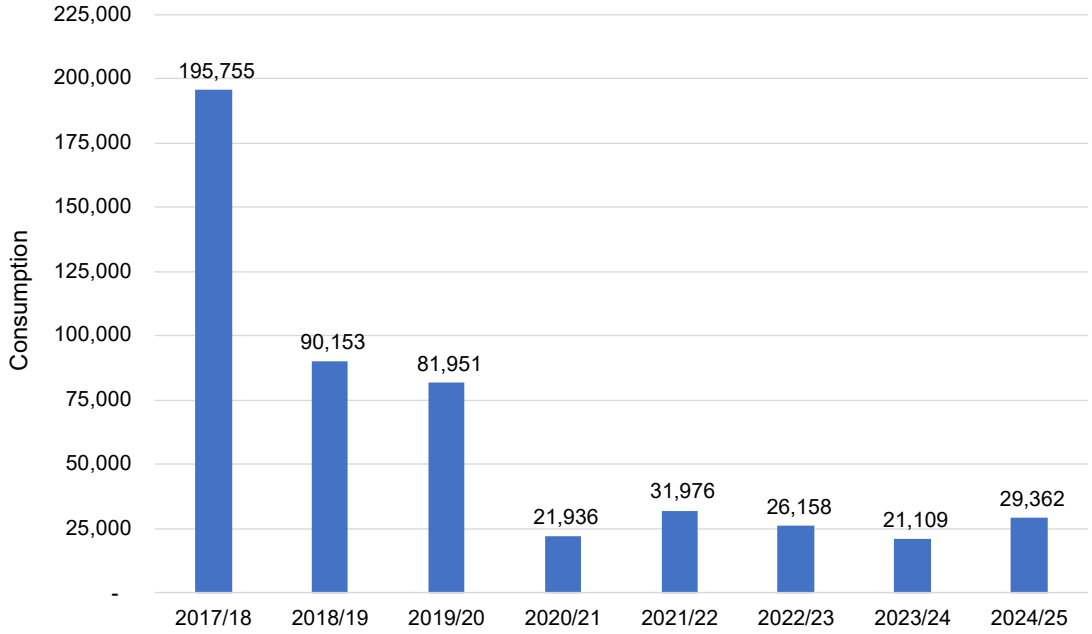
Consumer single-use plastics



Paper use



Water consumption (m^3)



Sustainable procurement

Our policy is outlined in the published net zero supplier roadmap[224], supported by guidance aligned with Procurement Policy Note (PPN) 002[225] on the Social Value Model and PPN 016[226] on Carbon Reduction Plans. Additionally, our Evergreen Sustainable Supplier Assessment tool[227] helps suppliers align with our net zero and sustainability goals. We are committed to eradicating modern slavery in line with PPN 009[228] and have integrated a risk assessment tool into our e-commerce system to support this effort.

Net zero and social value buying guides have been created to aid the development of specific category strategies, incorporating Government Buying Standards where relevant.

Nature recovery and biodiversity

We do not own any natural capital or landholdings.

Adapting to climate change

Business continuity management identifies our priorities and prepares solutions to address disruptive threats, including those which may be the result of climate change and extreme weather events.

[224] https://www.england.nhs.uk/greenernhs/get-involved/suppliers/
[225] https://www.gov.uk/government/publications/ppn-002-taking-account-of-social-value-in-the-award-of-contracts/procurement-policy-note-002-the-social-value-model-html
[226] https://www.gov.uk/government/publications/ppn-009-tackling-modern-slavery-in-government-supply-chains/ppn-009-guidance-on-tackling-modern-slavery-in-government-supply-chains-html
[227] https://www.england.nhs.uk/nhs-commercial/central-commercial-function-ccf/evergreen/
[228] https://www.gov.uk/government/publications/ppn-009-tackling-modern-slavery-in-government-supply-chains/ppn-009-guidance-on-tackling-modern-slavery-in-government-supply-chains-html

NHS emissions

As set out in the DHSC GAM, NHS bodies are not required to disclose emissions as part of the metrics and target pillar of TCFD disclosures, as NHS England provides estimates of NHS total emissions.

The breakdown of estimated 2024/25 NHS Carbon Footprint emissions into Scope 1, 2 and limited Scope 3 emissions is included below, aligning with reporting requirements for central government departments, plus additional categories that are included in the NHS Carbon Footprint definition.[229] These figures are rounded to the nearest 50 ktCO2e, are based on both actual and forecasted data as at end May 2025, and may be subject to revision as final input data is published. Updated figures for 2023/24, based on latest available 2023/24 data and methodology, are also included in the table. The intention for future reporting is to include additional Scope 3 emission categories.

NHS England is undertaking a review of emissions in the NHS footprint in line with best practice methodology, as well as progress made five years on from the 'Delivering a Net Zero NHS' report.

	Estates	Medicines	Fleet and business travel	Total (ktCO2e)
Scope 1	Onsite combustion of fossil fuels	Anaesthetics	Owned and leased fleet	
Estimated NHS emissions ($ktCO_2e$)	1,600	250	150	**2,000**
Scope2	Electricity / purchased heat and steam	-	-	
Estimated NHS emissions ($ktCO_2e$)	650	N/A	N/A	**650**
Scope 3	Well to tank emissions, waste and water	All inhalers and anaesthetic manufacturing	Business travel	
Estimated NHS emissions ($ktCO_2e$)	500	700	450	**1,700**
Total 2024/25 Provisional	**2,800**	**950**	**600**	**4,350**
Updated 2023/24	2,850	1,000	600	**4,450**

[229] https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2022/07/B1728-delivering-a-net-zero-nhs-july-2022.pdf